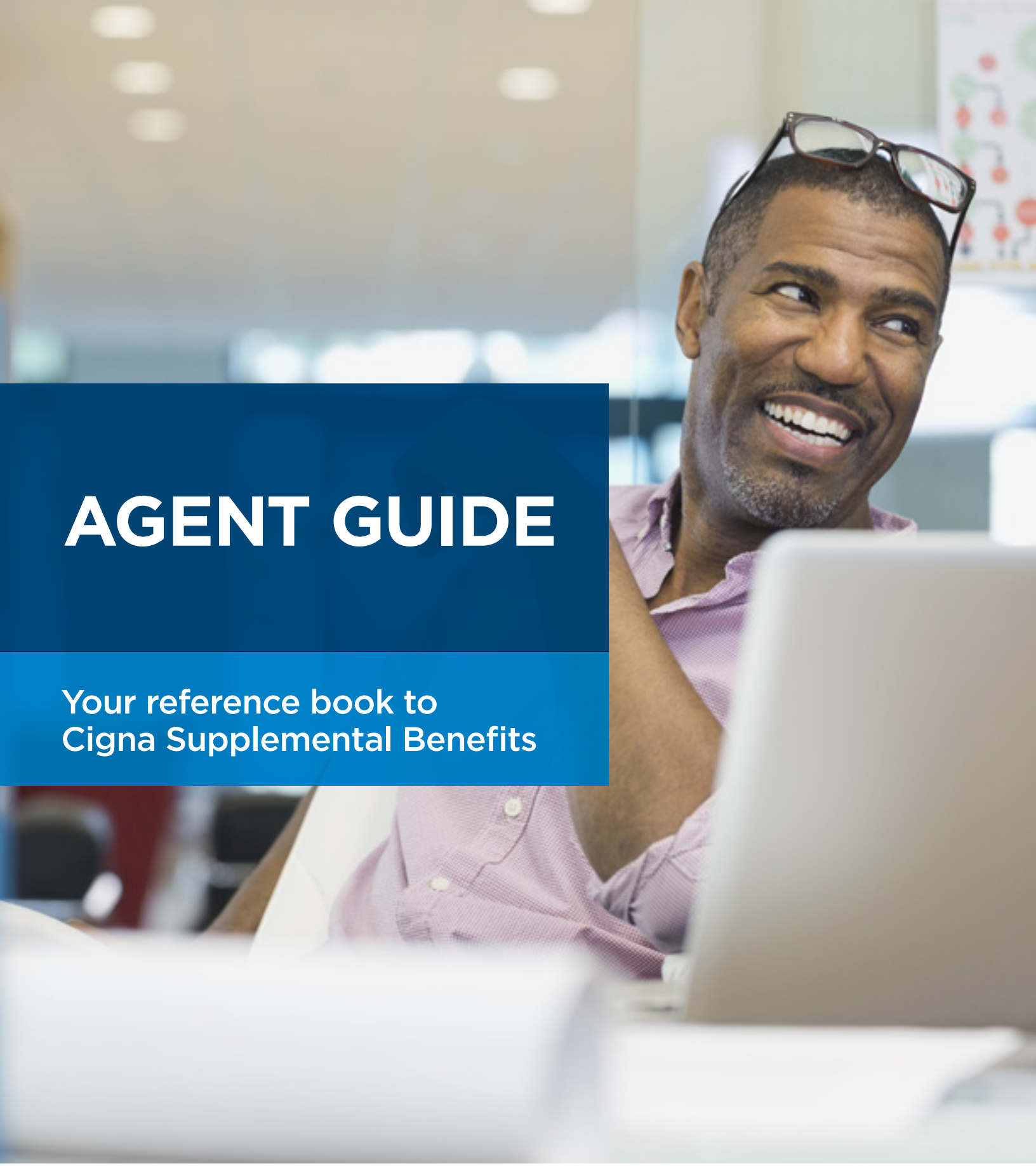

AGENT GUIDE

Your reference book to Cigna Supplemental Benefits

Together, all the way.℠

Cigna®

ARLIC-1-0008

AT CIGNA, WE BELIEVE THAT BEING TRUE TO YOURSELF IS THE FIRST STEP TO BEING TRULY HEALTHY.

That's how we run a healthy business, holding fast to our health service mission. That's how we generate value for our shareholders, staying true to our global growth strategy. That's how we attract the best employees, offering them ways to contribute their unique talents.

And that's how we serve our customers, encouraging them as they march to the beat of their own drummers – whether they dream of climbing mountains or lowering their cholesterol, running marathons or running companies, raising their heart rates or raising their families, planning for the future or leaving old habits behind.

We are a global health service company with a history in the insurance business that spans over 223 years. We maintain sales capability internationally in 30 countries and jurisdictions, with approximately 80 million customer relationships worldwide, and we are dedicated to helping the people we serve improve their health, well-being and sense of security.

At Cigna Supplemental Benefits, we offer solutions that help individuals and their families do just that. Our portfolio helps support the supplemental health and senior markets by offering the following solutions through American Retirement Life or Loyal American Life insurance companies:

- Medicare Supplement
- Whole Life Insurance
- Cancer
- Heart Attack & Stroke
- Critical Illness
- Accident

In the following pages, you will find the information you need to provide the quality and service your customers expect from Cigna. From products to technology, we have what you need to build your business. Submit error-free applications electronically with **EXPRESS APP,** get quotes on your mobile device and stay up to date with our virtual office, AgentView.

We are here to help you reach your full potential!

AgentViewCigna.com

AgentView is your virtual home office. Here, you will find the most up-to-date forms for your state, in addition to:

- **EXPRESS APP**
- Commissions
- Product Availability
- Agent Training
- Customer Information
- Brochures and Application Packets
- Production Reports
- News and Notices

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MEDICARE SUPPLEMENT

Part A and Part B expenses
not covered by Medicare

Introduction to Medicare Supplement

A Medicare Supplement policy is an individual supplemental health insurance plan that provides benefits for all or part of the deductible and coinsurance amounts not covered by Medicare. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) permits issuance of a Medicare Supplement policy to individuals who have other health insurance plans, such as Long-Term care, specified disease or hospital indemnity policies. However, it is unlawful to sell a Medicare Supplement policy to an individual who already has a Medicare Supplement policy, unless the new policy will replace the existing policy.

Basic benefits

- Hospitalization: Part A coinsurance, plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copays for hospital outpatient services. Plans K, L & N require insureds to pay a portion of Part B coinsurance or copays.
- Blood: First three pints of blood each year.
- Hospice: Part A coinsurance.

Medicare Supplement plans

The chart below shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in your state. See your state's Outline of Coverage for details about **all** plans.

PLAN	A	B	C	D	F*	G	K	L	M	N
Basic benefits including 100% Part B coinsurance	x	x	x	x	x	x	Hospitalization & preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization & preventive care paid at 100%; other basic benefits paid at 75%		
Hospice Part A coinsurance	x	x	x	x	x	x	x	x	x	x
Skilled nursing facility coinsurance			x	x	x	x	Paid at 50%	Paid at 75%	x	x
Blood (first three pints)	x	x	x	x	x	x	x	x	x	x
Part A deductible		x	x	x	x	x	Paid at 75%	Paid at 75%	Paid at 75%	x
Part B deductible			x		x					
Part B excess (100%)					x	x				
Foreign travel emergency			x	x	x	x			x	x
Out-of-pocket limit paid at 100% after limit reached							Out-of-pocket limit $4,800	Out-of-pocket limit $2,400		

*High-deductible Plan F – a high-deductible plan that pays the same benefits as Plan F, after one has paid the calendar year deductible. Benefits from high-deductible Plan F will not begin until out-of-pocket expenses exceed the calendar year deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

The sales process

Sales tools

› Outline of Coverage

› Brochure (optional)

› Application packet

› MyPolicyHQ.com (see "MyPolicyHQ.com" on page 59.)

Leave behind materials

Here is a list of marketing materials every agent should have when completing a sale. Some of these materials are required by your state.

› Outline of Coverage for state (required)

› Brochure (optional)

› Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (required)

› Replacement Form, if replacement Policy (contained in application packet, required)

› Any other state-specific forms included in your application packet to be left with applicant (required)

The new policy

› Policy: check to ensure that the issued policy matches the requested policy.

› Policy Identification Card: for your customer's use when purchasing health care services. A permanent laminated card will follow the delivery of the policy.

› Delivery Receipt: the insured is to sign the delivery receipt and return it to the administrative office. (In states where required.)

› Endorsements: your customer's policy may not be issued as applied for. If so, an endorsement indicating a different underwriting class is included with the policy, giving the applicant the opportunity to accept or decline the offer. If the offer is accepted, the endorsement must be signed by the customer and returned, filed and the account activated. The customer may call our New Business department and provide verbal authorization to accept the different underwriting class and a different premium, if applicable. Failure to return this signed endorsement or failure to call New Business within 30 days (free look period) will result in an automatic cancellation of the policy. (If the offer is declined, the policy is terminated as not taken.)

› There is an initial 12-month rate guarantee. Rate increases to each respective customer will be separated by at least 10 months.

Understanding the application

Outside open enrollment (excluding guaranteed issue)

› Submit a completed application. Health questions should be answered.

› A Phone Verification (PV) and a prescription database check will be required for all applicants.

During open enrollment

› The Medicare Supplement Open Enrollment (OE) period lasts six months. OE generally starts on the first day of the month in which the applicant is both, age 65 or older and enrolled in Medicare Part B. Check with your state for any additional Open Enrollment periods.

› Submit a completed application. Medical questions should not be answered.

› All plans for sale in the state of residence will be available.

Open enrollment/guaranteed issue quoting rules for plans* A, B, C, D, F, G and N

(Refer to guaranteed issue guidelines in the current CMS Guide, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.) In Connecticut: Persons under 65 with disabilities are guaranteed acceptance into Medicare Supplement plans A, B and C only.

Attained age and issue age states

During OE and guaranteed issue, plans should be quoted at the Preferred rate for the applicant's age, regardless of tobacco use. In Florida, regardless of Open Enrollment or guaranteed issue, plans should be quoted based on the applicant's age and tobacco usage, using the Tobacco and Nontobacco rates.

Disabled applicants under the age of 65

Applicants who are under the age of 65 and are disabled (according to Medicare qualification criteria) are generally not offered coverage unless an offer is mandated by the state in which they live. Refer to Medicare & You, the official government handbook, for details and updated state guidelines (also available online at medicare.gov). Applications must be mailed with a wet signature and a check.

Disenrollments/guaranteed issue

If the proposed insured loses health coverage under certain circumstances, he or she will have a guaranteed right to purchase Medicare Supplement Plans A, B, C or F offered by the company in the applicant's state.* He or she must apply within 63 calendar days following notification of loss of coverage or the actual date that coverage terminates. If the applicant applies after 63 calendar days, full underwriting will be required.

Check for any other specific rules in the applicant's state. Once you have determined that guaranteed issue circumstances apply:

› Complete an application with the proposed insured.

› Submit a copy of the disenrollment/termination letter, including the policyholder's name and termination date by fax, to 888.695.2591. Be sure to include the policy number. Additional documentation may be required for certain guaranteed issue rights.

› Medical questions should not be answered.

Household discount

If another member of your household is applying for or currently has a Medicare Supplement plan with American Retirement Life Insurance Company or an affiliated company, you may qualify for a Household Discount; see the Outline of Coverage for details. Make sure the applicant provides the name and Social Security number of the individual(s) living at their current address during the applicant process. Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex. Assisted Living Facilities, Group Homes, Adult Day Care facilities and Nursing Homes or any other health residential facility are not included in the definition of "Household."

› If household discount applies, then multiply the rate by 0.93.

*Check your state's Outline of Coverage for available plans.

Completing the application

All sections of the Medicare Supplement application must be completed. Make sure to refer to the application relevant to your state when reviewing this guide.

The following guidelines apply to all applications

- We accept Medicare Supplement applications for customers who are not current Medicare Supplement contract holders of companies insured or administered by Cigna Supplemental Benefits. This includes policy conversions and exchanges.
- Both the issue state and the residence state must be based on the applicant. Agents must be licensed to sell Medicare Supplement in the applicant's state of residence either by a state resident or nonresident license in order to take an application. Check your state's Outline of Coverage or our Product Availability Chart for availability.
- All agents must also use the current application packet for the insured's resident state at the time of application. Applications received for processing that are based on the agent's issue state and not the applicant's resident state will be returned.
- The requested effective date may not be more than 180 days from the date the application was signed for Open Enrollment cases only. For underwritten and guaranteed issue applications, the requested effective date may not be more than 60 days from the date the application was signed.
- Wisconsin applications may be taken up to 90 days prior to the insured becoming eligible.
- West Virginia applications may be taken up to 30 days prior to the insured becoming eligible.
- Check all calculations against the premium rate charts and/or rate tools, including plan code, area rating, age, household discount, etc. Be sure to use the correct modal factor on the rate chart.
- A Phone Verification (PV) interview must be conducted on Medicare Supplement applicants with the exception of Open Enrollment or Guaranteed Issue applications submitted with a wet signature. (See "Phone Verification (PV)" on page 55.)
- Payer/payee guidelines: Each policy is an individual contract. Premium payments will be accepted only from the policyholder or an immediate family member. No third-party payers will be accepted.
- It is illegal to sell a Medicare Supplement plan to an individual with Medicaid except in certain situations. If the applicant answers "Yes" to question #2 in Section V of the application, then the Company can only sell them Medicare Supplement coverage if one of the following conditions are true:
- Medicaid pays their Medicare Supplement premium; or
- Medicaid only pays all, or part of, the Medicare Part B premium.
- Thus, after the applicant discloses that they are covered by Medicaid, either question #2a must be answered "Yes" or question #2b must be answered "No." Otherwise the policy cannot be issued.
- Confirm whether the Medicaid coverage is ending prior to the Medicare Supplement requested effective date. If so, enter this information into the 'Agent Notes' section under Part C of the Medicare Supplement application.
- Individuals losing Medicaid are eligible for guarantee issue within 63 days in the following states: KS, ME, TN, TX, UT and WI.

For written applications

Note: Use black ink pen on all documents — no marker pens.

- Draw a line through any errors and have the applicant initial corrections. Do not use correction fluid or similar measures.
- Applications must be submitted within 30 days of the signed application date and cannot have a requested effective date prior to the date the application is signed.

- The requested effective date may not be more than 180 days from the date the application was signed for Open Enrollment cases only. For underwritten and guaranteed issue applications, the requested effective date may not be more than 60 days from the date the application was signed.
- Initial full modal premium or signed a Pre-Authorized Collection (PAC) form must be submitted with all applications.
- All applications must be signed by the policy owner. A power of attorney (POA) is not acceptable, except for OE/GI cases. Proof of POA is required. If any other applicants have assigned a POA to another individual and the POA is currently relied upon for handling the financial affairs of the applicant, then such applicant is not eligible for coverage. (A Phone Verification acts as a wet signature when selling over the phone or using **EXPRESS APP** (see "EXPRESS APP" on page 53.)
- We do not accept stamped signatures from either agents or applicants.
- If applicable, all state-required forms (e.g., replacement, state disclosure and disenrollment/termination letter) should accompany the application at the time of submission.
- A HIPAA Authorization must always be signed and submitted with the application.

Application submission options

- Online via **EXPRESS APP**, our web-based application tool (see "EXPRESS APP" on page 53.)
- Fax via our FaxApp Program (see "FaxApp Program" on page 53.)
- Standard mail, wet signature required.

Underwriting guidelines

All applications will be fully underwritten, unless the applicant qualifies for Open Enrollment or guaranteed issue. Our underwriting process includes a Phone Verification (see "Phone Verification (PV)" on page 55) prescription drug screening and a check with the Medical Information Bureau (MIB). If an application is submitted as any rate class that does not meet our criteria, you will be notified. A notice of premium due and approved rate class coverage schedule page will be sent with the policy and the application will be held until we receive the additional premium and signed schedule page. **Standard II & III rate classes are not available to applicants under age 65. Normal underwriting rate classes and rules apply.**

Preferred rate class (in FL, Nontobacco)

- All medical questions in Part A and Part B must be answered "No."
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-MS) for listed use only.
- The applicant's height and weight must be between the "Minimum Weight" and "Maximum Weight " found in our height and weight chart (see "Height and weight charts" on page 57).
- The applicant must not have any of the selected conditions listed below. (Not applicable in ID, MN, MI and OR.)
- The applicant must not have used tobacco within the last 12 months.

Standard rate class (in FL, Tobacco)

- All medical questions in Part A and Part B must be answered "No."
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-MS) for listed use only.
- The applicant's height and weight must be between the "Minimum weight" and "Maximum weight with selected conditions" found in our height and weight chart (see "Height and weight charts" on page 57).
- The applicant must not have any of the conditions listed in the selected conditions section. (Not applicable in ID, MN, MI and OR.)
- The applicant is a tobacco user or has used tobacco in the last 12 months.

Standard II rate class*

› All Medical questions in Part A must be answered "No."

› The applicant is not taking any of the drugs listed on our listed as 'Declinable' on the drug list (CSB-9-0017-MS.)

› Applicant answers 'Yes' to any question in Part B of the Medical Questions, or is taking a drug listed in the Std II or Std III column of the declinable drug list that does not have an 'X'

› The applicant's height and weight is outside the limits of the height and weight charts (see "Medicare Supplement and Companion Whole Life" on page 57.)

› The applicant's has selected conditions and weight is outside the limits of height and weight with selected conditions (see "Medicare Supplement and Companion Whole Life" on page 57.)

› The applicant must not have used tobacco within the last 12 months

Standard III rate class*

› All Medical questions in Part A must be answered "No."

› The applicant is not taking any of the drugs listed on our listed as 'Declinable' on the drug list (CSB-9-0017-MS).

› Applicant answers 'Yes' to any question in Part B of the Medical Questions, or is taking a drug listed in the Std II or Std III column of the Declinable Drug List that does not have an 'X'

› The applicant's height and weight is outside the limits of the height and weight charts (see "Medicare Supplement and Companion Whole Life" on page 57.)

› The applicant has selected conditions and weight outside the limits of height and weight with selected conditions (see "Medicare Supplement and Companion Whole Life" on page 57.)

› The applicant is a tobacco user or has used tobacco in the last 12 months

Selected conditions

No longer declinable if Standard II or Standard III rates are available in your state.*
(Not applicable in ID, MN, MI and OR.)

› Diabetes with tobacco use.

› Diabetes with hypertension taking more than two medications to control blood pressure.

› Diabetes with weight above the "Maximum weight with selected conditions."

› Tobacco use with weight above the "Maximum weight with selected conditions."

› Diabetes with circulatory or cardiovascular conditions.

› Circulatory or cardiovascular conditions with weight above the "Maximum weight with selected conditions."

› Circulatory or cardiovascular conditions with tobacco use.

When checking your customer's medications against the Declinable Drug List (CSB-9-0017-MS) always determine how that medication is used. Prescription medications may be used for multiple reasons. Insurability is based on the conditions listed on the actual application. Our underwriting department will have the final determination in all cases.

Important note: The Medicare Supplement business will be issued at the rate class requested by the agent. If the applicant does not qualify for the requested rate class, the next appropriate rate class will be applied.

* STD II and III rate classes are not available in all states. Check your state's Outline of Coverage or our Product Availability Chart.

Premium calculations and payments

One-time enrollment fee

There is a one-time enrollment fee (except in AR & WV) of $20.00 ($6.00 in MS) for each new application.

Premium modes

Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.

Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

Mode	Bank Draft	List Bill	Direct Bill
Monthly	0.0833*	0.090*	N/A
Quarterly	0.265	0.265	0.265
Semiannually	0.520	0.520	0.520

*For ID, MI, MN and OR the rate is 0.085.

Rate classes

Preferred (nontobacco user), Standard (tobacco user), Standard II (nontobacco user) and Standard III (tobacco user). (In Florida, nontobacco and tobacco.)

How to calculate premiums

If you are away from a computer or cannot access **EXPRESS APP**, you can calculate the premiums manually using the instructions below.

› Determine the age of the insured by looking at the date the application was signed, not the requested date of coverage.

› Determine the correct rates by using the first three digits of your customer's ZIP code.

› Decide which mode of premium payment you will use. Multiply the annual premium by the applicable factors to obtain the appropriate rate. **Example: $1,200 (annual premium) x 0.520 (semiannual) = $624 semiannual rate. For ID, MI, MN and OR the rate is 0.085.**

› If household discount applies then multiple the rate by 0.93.

Bank drafts

Medicare Supplement policies will draft premiums on the effective date or the customer's chosen draft date following the effective date.

Additional reference tools

The website for the Medicare program, www.medicare.gov, contains information regarding the program. It also contains the most popular publications listed below. You can view, print or order publications online, or by calling 800.MEDICARE (800.633.4227). Some of these publications can be printed directly from the website.

› Medicare & You

› Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare

› Your Medicare Benefits

Many other publications also have valuable information. For example, The National Underwriter Company annually updates All About Medicare; its guide to the program.

Extra services

Please note: Not all extra services are offered in all states; availability may vary. Customer programs cannot be used as an inducement to purchase a Medicare Supplement insurance policy, and are not allowed to be discussed or promoted during the sales process. Information is here for reference only should an agent receive a question from a policyholder. Please consult your state's Medicare Supplement consumer brochure for information to be shared at the time of sale.

Medicare Supplement customers receive full details and sign-up information with their new policy kit. Existing customers can contact our customer service department at 866.459.4272 to request full details.

Customer programs are not guaranteed insurance benefits with our Medicare Supplement insurance policies and services may be added or discontinued. All customer programs are provided through third-party vendors and are not administered by American Retirement Life Insurance Company.

24-hour health information

› A 24-hour health information line to answer medical questions for Medicare Supplement customers anytime.

The Silver&Fit® program

› Provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas.

› Low-cost ($25) access to a fitness club or exercise center.

› Group classes made for older adults, where offered.

› Low-cost ($10) option to work out at home using up to two home fitness kits per year (15 to choose from).

› Healthy aging materials (online or DVD).

› A newsletter four times a year.

› Silver&Fit Connected!™, a fun and easy way to track exercise at a facility or through a wearable fitness device or app and earn rewards. (Rewards subject to change; purchase of device or app is not included.)

› Other web tools like a facility search, health articles, challenges and more.

Cigna Healthy Rewards®*

A discount program to help customers save on health products and wellness programs. Healthy Rewards programs are separate from medical benefits.

› Weight management and nutrition – Jenny Craig®.

› Vision exams and eyewear – Pearle Vision®, JCPenney Optical®, Sears® Optical, etc.

› Hearing aids and exams – HearPO®, drugstore.com™ and more.

› Alternative medicine – chiropractic, acupuncture and massage services.

USA Senior Care Network Premium Savings Program

A policyholder can receive a $100 credit off of a future premium payment if the policyholder goes to a participating hospital that is part of the USA Senior Care Network and has an inpatient stay that requires payment of a Part A deductible. The network arrangement is non-restrictive and has no impact on the policyholder's freedom to visit any provider who accepts Medicare. This program is purely a savings opportunity. Policyholders can find hospitals that are part of USA Senior Care Network by calling USA Senior Care at 800.872.3860.

Note: This program is not available on Plan A. USA SCN cannot be discussed pre-sale under any circumstances. Please refer Medicare Supplement policyholders to their extra services brochure for more information.

*Healthy Rewards programs are separate from your medical benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge.** Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. Participating providers are independent contractors solely responsible for any care or services provided.

COMPANION WHOLE LIFE

Benefits to help cover funeral and final expenses

Introduction to Companion Whole Life

Our Simplified Issue Companion Whole Life policy is designed to help your customer pay funeral expenses and final expenses. Our Whole Life policies feature guaranteed level premiums while accumulating cash value. An Accelerated Benefit Terminal Illness Rider is included in each policy for no additional premium. Life policy will be underwritten based on answers to the health questions on the application.

Basic features

- Issue ages: 64–85
- Available benefit amounts: $5,000–$25,000 (in $1,000 increments).
- Renewability: Guaranteed renewable for life, except for nonpayment of premiums.
- Cash value: This policy accumulates cash value. The available amount can be accessed through policy loans or cash surrender.
- Premiums: The premiums are guaranteed never to increase.

Accelerated Benefit Terminal Illness

Each policy comes with an Accelerated Benefit Terminal Illness rider for no additional premium. When diagnosed with a terminal illness, the customer can request up to 50% of the policy's death benefit in either a lump sum benefit amount or in periodic payments.

The sales process

Must be sold with a new Medicare Supplement policy or to an existing CSB Med Supp customer.

Sales tools

Anti-Money Laundering (AML) training – Required prior to the sale of our Whole Life product (see "Anti-Money Laundering (AML) training" on page 12.)

- Agent training flyer (optional).
- Combo application – Available as an add-on to any Med Supp application.
- Separate application – Through our family of companies, all of your existing, in-force Med Supp customers can add a Whole Life Insurance policy through a separate application.

Marketing, Sales or Solicitations for any non-health related insurance policies (i.e., life, accident or disability income) cannot be conducted if solely based on use of the HIPAA protected health information of an insured person under a former or existing health policy.

Anti-Money Laundering (AML) training

Required training

Before you can sell a Whole Life policy, you must complete Anti-Money Laundering training. You may have completed similar training with other vendors or carriers; however, CSB requires that you complete the LIMRA courses as outlined below.

› If you have never completed LIMRA AML training, you will need to complete the initial Anti-Money Laundering for Insurance Producers course found on the LIMRA website prior to writing any Life product with any of our companies.

› If you have already completed this course, you will have to complete the LIMRA refresher course for the current year.

› If you have any questions about our AML training program requirements, please contact Agent Licensing at 877.454.0923.

We cannot accept business for Whole Life from agents that have not completed the required AML training.

LIMRA training instructions

Visit https://aml.limra.com and enter your username and password in lowercase letters in the spaces provided. (The login function is case sensitive.) Your username is the first four letters of your last name plus the last six digits of your Social Security number. If this is your first time accessing the course, your password is your last name. For example, John Smith, whose Social Security number is 000-12-3456, would have the following username and password:

› Username: smit123456

› Password: smith

You will then be prompted to change your password. (If you have previously accessed the LIMRA site, please use the password created at that time. Online help is available through the Forgot Your Password link if you do not recall your password.)

Complete one of the following courses:

› Anti-Money Laundering for Insurance Producers. Complete this course if it is your first time completing an AML course through LIMRA.

› Complete refresher course for the current year if you have previously completed Anti-Money Laundering for Insurance Producers through LIMRA. There are two versions of the course available, one with Flash enabled and one without. You are only required to complete one of these versions.

CSB will automatically receive notification of your course completion. You will not receive a certificate of your completion of the course. The home page indicates whether or not you have completed the assigned material.

Should you have technical questions accessing or navigating within the LIMRA site, please contact LIMRA's technical support partner's help desk at support@cfmpartners.com or 866.364.2380 (see "Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Supplemental Benefits (CSB)" on page 69.)

Premium calculations and payments

Annual policy fee

There is a $36 (may vary by state) annual policy fee applied to each Whole Life policy. This non-commissionable fee is included in the rates shown on the Rate Sheets (ARLIC-4-0001, found on AgentView.)

Premium modes

Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill. Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

How to calculate premiums

If you are away from a computer or cannot access **EXPRESS APP**, you can calculate the premiums manually using the instructions below.

- Determine the age of the insured by looking at the date the application was signed, not the requested date of coverage.
- Decide which mode of premium payment you will use (annual, semiannual, quarterly and monthly). For modes other than monthly, use the appropriate conversion formula:

annual =	semiannual =	quarterly =
monthly premium x 11.43	monthly premium x 5.94	monthly premium x 3.03

- Multiply the monthly premium by the applicable factors to obtain the appropriate rate. **Example: $33.35 (monthly premium) x 5.94 (semiannual) = $198.10 semiannual rate**

Bank drafts

Life policy premiums will draft on the same date as the customer's Med Supp policy.

Underwriting guidelines

All application will be fully underwritten. Our underwritting process includes a Phone Verification (see "Phone Verification (PV)" on page 55), prescription drug screening and a check with the Medical Information Bureau (MIB).

- All medical questions in Part A must be answered "No."
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-MS, found on AgentView) for listed use only.
- The applicant's height and weight must be between the "Minimum Weight" and "Maximum Weight " found in our height and weight chart (see "Medicare Supplement and Companion Whole Life" on page 57.)
- The applicant must not have any of the comorbids listed below.

Comorbids

Declinable (Not applicable in ID, MN, MI and OR.)

- Diabetes with tobacco use.
- Diabetes with hypertension taking more than two medications to control blood pressure.
- Diabetes with weight above the "Maximum weight with comorbids."
- Tobacco use with weight above the "Maximum weight with comorbids."
- Diabetes with circulatory or cardiovascular conditions.
- Circulatory or cardiovascular conditions with weight above the "Maximum weight with co-morbids."
- Circulatory or cardiovascular conditions with tobacco use.

When checking your customer's medications against the Declinable Drug List (CSB-9-0017-MS) always determine how that medication is used. Prescription medications may be used for multiple reasons. Insurability is based on the conditions listed on the actual application. **Our Underwriting department will have the final determination in all cases. Congestive heart failure and cardiomyopathy are declinable conditions.**

INDIVIDUAL WHOLE LIFE

Benefits to help your customers protect their financial interests

Introduction to Individual Whole Life

Our Individual Whole Life Insurance policy is designed to help your customers to prepare for a wide range of necessities and protect what is most important to them. Our Individual Whole Life policies feature guaranteed level premiums while accumulating cash value starting in the third year, that can be accessed by either a policy loan or cash surrender.

Basic features

- Issue ages: 50–85
- Available benefit amounts: $2,000–$25,000 in $1,000 increments; may include other incremental benefit amounts such as $2,500, $7,500 and $12,500. Maximum benefit amount is $25,000.
- No annual policy fee
- Cash value: The net cash value is payable if the insured is living at age 121. The policy may not qualify as life insurance after the insured has attained age 121 under federal tax law and the policy may be subject to adverse tax consequences. A tax advisor should be consulted.
- Premiums will not increase
- 5% spousal premium discount*

Benefit plans

Two benefit plans, Level or Modified Benefit, allow coverage for a wide variety of health conditions. The Life policy will be underwritten based on answers to the health questions on the application, which will determine the eligibility for the Level or Modified benefit. The Level Benefit Plan will pay the full death benefit amount chosen to their beneficiary upon their death. The Level Benefit Plan automatically includes a Terminal Illness Accelerated Benefit Rider. Should your customer be diagnosed with a terminal illness, they can request a percentage of the policy's death benefit, not to exceed 50%, in a lump sum benefit amount prior to death.**

The Modified Benefit Plan has adjusted levels of coverage for the first two years of the life of the policy, as shown in the chart below:**

Loss of life from:	Death Benefit Amount
Accidental death while covered	100% of benefit
Non-accidental death within first two years of coverage	100% of premium paid + 10%
Non-accidental death after being covered for two or more years	100% of benefit

Optional rider

Accidental Death Benefit to Age 100 rider***

Form #ICC14-LY-ADBR

We offer our Accidental Death Benefit to Age 100 rider with death benefit amounts ranging from $10,000 to $50,000 if death occurs within 180 days as a direct result of an accidental injury while covered under the policy and this rider is in force.*** If death from the accidental injury occurs after the rider terminates, this benefit is payable provided the accidental injury was sustained while the rider was in force, and death occurs within 180 days of the injury.**

*Only available if both individuals apply at the same time.
**Subject to all terms and conditions of the policy and/or rider.
***Rider available for an additional premium.

The sales process

Individual Whole Life may be sold as a stand-alone policy and does not need to be sold with a new Medicare Supplement policy or to an existing CSB Med Supp customer.

Sales tools

Anti-Money Laundering (AML) training – Required prior to the sale of our Whole Life product (see "Anti-Money Laundering (AML) training" on page 16.)

- Agent Training Flyer (optional)
- Application packet
- Rate Booklet
- EXPRESS APP

Marketing, sales or solicitations for any non-health related insurance policies (i.e., life, accident or disability income) cannot be conducted if solely based on use of the HIPAA protected health information of an insured person under a former or existing health policy.

Anti-Money Laundering (AML) training

Required training

Before you can sell a Whole Life policy, you must complete Anti-Money Laundering training. You may have completed similar training with other vendors or carriers; however, CSB requires that you complete the LIMRA courses as outlined below:

- If you have never completed LIMRA AML training, you will need to complete the initial Anti-Money Laundering for Insurance Producers course found on the LIMRA website prior to writing any Life product with any of our companies.
- If you have already completed this course, you will have to complete the LIMRA refresher course for the current year.
- If you have any questions about our AML training program requirements, please contact Agent Licensing at 877.454.0923.

We cannot accept business for Whole Life from agents that have not completed the required AML training.

LIMRA training instructions

Visit https://aml.limra.com and enter your username and password in lowercase letters in the spaces provided. (The login function is case sensitive.) Your username is the first four letters of your last name plus the last six digits of your Social Security number. If this is your first time accessing the course, your password is your last name. For example, John Smith, whose Social Security number is 000-12-3456, would have the following username and password:

- Username: smit123456
- Password: smith

You will then be prompted to change your password. (If you have previously accessed the LIMRA site, please use the password created at that time. Online help is available through the Forgot Your Password link if you do not recall your password.)

Complete one of the following courses:

- Anti-Money Laundering for Insurance Producers. Complete this course if it is your first time completing an AML course through LIMRA.
- Complete refresher course for the current year if you have previously completed Anti-Money Laundering for Insurance Producers through LIMRA. There are two versions of the course available, one with Flash enabled and one without. You are only required to complete one of these versions.

CSB will automatically receive notification of your course completion. You will not receive a certificate of your completion of the course. The home page indicates whether or not you have completed the assigned material.

Should you have technical questions accessing or navigating within the LIMRA site, please contact LIMRA's technical support partner's help desk at support@cfmpartners.com or 866.364.2380. (See "Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Supplemental Benefits (CSB)" on page 69.)

Premium calculations and payments

Annual policy fee

There is no annual policy fee on the Individual Whole Life policy.

Premium modes

Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.

Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

How to calculate premiums

If you are away from a computer or cannot access EXPRESS APP, you can calculate the premiums manually using the instructions below.

› Determine the age of the insured by looking at the date the application was signed, not the requested date of coverage.

› Find the rates for modals not displayed, multiply the annual rate by the modal factor listed below.

Mode	Bank Draft	Direct Bill
Monthly	0.0875	N/A
Quarterly	0.265	0.265
Semiannual	0.520	0.520

Spousal discount

If the applicant is applying at the same time with their spouse/domestic partner, a spousal discount of 5% can apply. Follow the instructions below to calculate the discounted rate.

Note: For proper premium and rating for couples, the discounted spousal rate will always apply to the youngest applicant. Either spouse may be listed as the primary applicant; however, the discounted rate can only apply to the younger applicant. Entering the incorrect premium will result in processing delays and require submission of a new, corrected application.

Use the rate as displayed on Rate Chart for age, benefit level, etc. Take the rate you wish to apply the spousal discount to and multiply by .95 (95%).

Example: $44.75 (listed rate) x .95 (spousal discount) = $42.51 (discounted rate you would enter onto the application)

Underwriting guidelines

All applications will be fully underwritten. Our underwriting process includes a Phone Verification (see "Phone Verification (PV)" on page 55,) Rx Check Lookup, Declinable Drug List (DDL) with applicable drugs obtained from Rx Check Lookup, and a check with the Medical Information Bureau (MIB).

- Questions 1–7: "Yes" answer to any question = no coverage issued
- Questions 8–11 "Yes" answer to any question = Modified Benefit Plan coverage issued
- "No" answer to all questions = Level Benefit Plan coverage issued
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-IWL, found on AgentView) for listed use only. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on the Declinable Drug List. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.
- When checking your customer's medications against the Declinable Drug List (CSB-9-0017-IWL) always determine how that medication is used. Prescription medications may be used for multiple reasons. Insurability is based on the conditions listed on the actual application. Our Underwriting department will have the final determination in all cases.

For level benefit plan eligibility

- Must answer "No" to **all** questions in Section VII.
- Congestive heart failure and cardiomyopathy are declinable conditions.

For modified benefit plan eligibility

Can answer "Yes" to questions 8–11 in Section VII.

- **Between 12 months and 4 years** for cancer (except skin cancer).
- **Within past 2 years:** For emphysema, COPD, chronic bronchitis, stroke or TIA, MS, Parkinson's, kidney disease other than infection or kidney stones.
- **Within past 12 months:** Alcoholism, alcohol abuse, drug or substance abuse treatment, counseling or recommendation to seek treatment.
- **Diagnosed with or treated for:** As having diabetes before age 30, complications from diabetes or diabetes requiring more than 50 units of insulin to control.

For ARLIC appointed agents: Once you submit your first application for Individual Whole Life (or any Loyal American product), we will automatically appoint you to Loyal American Life Insurance Company at the same level as in ARLIC.

CRITICAL CHOICE CANCER & HEART

Lump sum benefits for first diagnosis
of cancer or heart conditions or stroke

Introduction to Critical Choice

Basic features

- Issue ages: 18–80
- Available benefit amounts: $5,000–$50,000
  (Must be the same for all insureds; however, maximum coverage for children is limited to the lesser of $10,000 or the parent benefit amount.)
- Renewability: Guaranteed renewable for life*
- Recurrence benefit: Included for no additional premium
- Available riders: First Diagnosis Cancer, First Diagnosis Heart Attack & Stroke, Accidental Death & Dismemberment and Specified Disease

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Refer to the Exclusions and Limitations in the brochure.

Cancer

(also available as a rider on a Heart policy)

Our Critical Choice Cancer Insurance provides a lump sum benefit payable on the first diagnosis of cancer (invasive) or carcinoma in situ (non–invasive cancer). Customers will receive 100% of the selected benefit amount upon first diagnosis of cancer and 25% of the selected benefit amount upon first diagnosis of carcinoma in situ. Any First Diagnosis Benefit amount payable for cancer shall be reduced, dollar–for–dollar, by any amounts previously paid for carcinoma in situ. The partial First Diagnosis Benefit for carcinoma in situ is payable once per insured's lifetime. Benefits are paid directly to the insured or their designee.

Cancer Insurance Coverage	Percentage of Selected Benefit Amount
Cancer (invasive)	100%
Carcinoma in situ (non-invasive cancer)	25%

Recurrence benefit

This product contains a unique Recurrence Benefit which pays a percentage of the First Diagnosis Benefit amount each time an insured receives a diagnosis for the recurrence of cancer or carcinoma in situ (see table below for a list of the percentages payable). The maximum total percentage of the Recurrence Benefit amount payable is an additional 100% of the First Diagnosis Benefit amount shown on the Policy Schedule Page. For the Recurrence Benefit to be payable:

- 100% of the First Diagnosis Benefit amount shall have been previously paid for the insured;
- The insured shall not have received any advice or treatment for at least 24 consecutive months prior to the date of diagnosis for the recurrence of cancer or carcinoma in situ.

Time Period Without Advice or Treatment	Percentage of Recurrence Benefit Amount Payable for Cancer	Percentage of Recurrence Benefit Amount Payable for Carcinoma in Situ**	Max. Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months through 5 years	25%	10%	
5 years through 10 years	75%	25%	
More than 10 years	100%	25%	

*Subject to the Company's right to increase premiums on a class basis.
**We will pay the benefit for carcinoma in situ only once in an insured person's lifetime

Reduction of benefits

There is a reduced benefit for the first 30 days immediately following the effective date of the policy. We will pay 10% of the benefit amount for a first-ever diagnosis of cancer, or 2.5% of the benefit amount for carcinoma in situ. If this reduced benefit is paid, coverage for the insured under the policy will terminate.

Heart Attack & Stroke

(also available as a rider on a Cancer policy)

Our heart attack and stroke insurance provides a lump sum benefit payable on the first diagnosis or procedure for one of the qualifying heart-related events shown in the chart below.

The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions.

Qualifying events	Percentage of benefit amount payable for each qualifying event	
Heart attack	100%	Maximum percentage of benefit amount payable 100%
Heart transplant	100%	
Stroke	100%	
Coronary artery bypass surgery*	25%	
Aortic surgery*	25%	
Heart valve replacement/repair surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

The sales process

Note: When using **EXPRESS APP**, if one or more applicants have been declined for a policy or rider based on the answer(s) provided to the medical questions. Please remove the rider and/or applicant to proceed.

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (if applicable)

The use of a Customer Booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

Rates

Premiums are based on issue age and banded for children ages 0–17, ages 18–29 and then five-year age bands from ages 30 to 80.

› Male or female rates are listed for both Tobacco and Nontobacco usage.

› Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.

› Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

› Rates are guaranteed for the initial 12 months.

› There is no policy fee or enrollment fee.

Mode	Bank Draft	List Bill	Direct Bill
Monthly	0.085	0.090	N/A
Quarterly	0.265	0.265	0.265
Semiannual	0.520	0.520	0.520

Optional benefits

(available for an additional premium)

Accidental Death & Dismemberment rider

Pays the Accidental Death & Dismemberment Benefit amount when an insured suffers loss of life or dismemberment due to injuries received in a covered accident. The loss must occur no later than 90 days after the date of the accident. The total amount payable under this benefit for all losses resulting from any one covered accident shall not exceed the amount payable for loss of life. Available amounts are $25,000, $50,000, $75,000 and $100,000. Benefit choice must be the same for all insureds; however, maximum combined coverage for children will be limited to $25,000.

Type of loss	% Payout
Life	100%
One eye, hand, foot, arm or leg	10%
More than one eye, hand, foot, arm or leg	20%

Specified Disease rider

Pays the selected benefit amount when the insured is diagnosed with any one of the covered specified diseases. Available in amounts of $5,000 to $50,000. The maximum child benefit amount is the lesser of $10,000 or the parent benefit. If two or more diseases are diagnosed in the same day, we will only pay one benefit amount. Each insured person is limited to one covered specified disease benefit amount.

Covered Specified Diseases: Amyotrophic lateral sclerosis (ALS); coma; end stage renal failure; major organ transplant; multiple sclerosis (MS); paralysis and severe burns.

Underwriting guidelines

Individuals who are currently covered by Supplemental Health Coverage and Title XIX programs (Medicaid, MediCal or any similar name).

Be sure to consult the eligibility instructions on the individual state applications for the guidelines and restrictions for coverage in certain states. Please note that the underwriter will make the final determination in all cases.

Medical conditions including; but not limited to, those listed below are not insurable for any coverage:

- Acquired immune deficiency syndrome (AIDS)
- AIDS related complex (ARC)
- Human immunodeficiency syndrome (HIV)

Cancer policy and rider

Medical conditions including; but not limited to, those listed below are not insurable for any coverage under the base policy/rider:

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include nonmelanoma skin cancers, premalignant lesions or benign tumors or polyps

Blood cancer including; but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative Disorders; including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Dysplasia of the cervix classified as level 3 or higher. This includes, but is not limited to:

- CIN III (cervical intraepithelial neoplasia level 3)
- HSIL (high grade squamous intraepithelial lesion)
- Severe dysplasia

Heart Attack & Stroke policy and rider

Medical conditions including; but not limited to, those listed below are not insurable for any coverage under the base policy/rider. Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots, including but not limited to:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease
- Pulmonary hypertension

Connective tissue diseases including, but not limited to:

- Ehlers–Danlos syndrome
- Marfan syndrome
- Osteogenesis imperfecta
- Pseudoxanthoma elasticum (PXE)
- Rheumatoid arthritis
- Scleroderma
- Sjögren's syndrome
- Stickler syndrome

Diabetes associated with insulin use (excluding gestational diabetes), neuropathy or retinopathy.
High blood pressure for which three or more medications have been taken concurrently.

Accidental Death & Dismemberment rider

The following occupations are not acceptable for coverage under the Accidental Death & Dismemberment rider:

- Asbestos and toxic chemical workers (including exterminators)
- Athletes (professional and semi–professional, but excluding golfers and bowlers)
- Aviators and crop dusters
- Bar and tavern owners, bouncers, and bartenders in establishments where greater than 50% of revenues come from liquor sales
- Circus and carnival workers
- Correctional facility workers
- Demolition, explosive and wrecking workers
- Drivers (including explosive haulers, mine and logging drivers, test drivers, race drivers)
- Entertainers, actors, actresses, stunt persons, exotic dancers, models, escort services
- Fishing industry (commercial, not returning to port each night)
- Halfway house workers for alcohol and drug rehabilitation
- Hazardous materials
- Jockeys, horse trainers and wild animal trainers
- Law enforcement and security personnel (field personnel only)
- Fire department workers (including volunteer firemen)
- Logging, mill workers, tree trimmers and tree surgeons
- Massage parlor (excluding licensed massage therapists)
- Meat packers and slaughterhouse workers
- Migrant workers and missionary workers
- Mining, quarry and foundry workers
- Musicians (touring non–classical musicians only)
- Oil rig, natural gas workers, onshore and offshore drilling
- Pyrotechnic technicians
- Rodeo participants
- Structural steel and iron workers and steeple jacks
- Tattoo artist/tattoo parlor owner
- Underwater, tunnel and caisson workers
- Unemployed (including applicants recently laid off, temporarily unemployed, or between jobs)

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-SS-LOYAL) helps agents identify possible uninsurable conditions. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on this application. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.

Height and weight chart

A height and weight chart (see “Critical Choice Cancer and Heart Attack & Stroke” on page 58) will be used for adults who apply for the Heart Attack & Stroke base policy/rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider. This chart will also be used when the above riders are applied for under the Flexible Choice Cancer product.

CASH ADVANTAGE® CRITICAL ILLNESS

Lump sum cash benefits for
one or more of 15 critical illnesses

Introduction to Cash Advantage® Critical Illness

Our Cash Advantage® Critical Illness insurance provides lump sum cash benefits should an insured be diagnosed with one of 15 covered critical health conditions. Cash Advantage® provides three benefit categories consisting of Cancer, Heart/Stroke Conditions, and other Critical Illness Conditions as defined in the policy. The maximum Critical Illness Benefit selected at the time of application is a "per category" maximum, so a customer could receive 100% of the Benefit Amount under each category.* The percentage of the Benefit Amount payable for each specified critical illness is shown in the Outline of Coverage.

Basic features

- Issue ages: 18–59*
- Available benefit amounts: $10,000–$50,000
  (Must be the same for all insureds; however, maximum coverage for children is limited to $10,000.)
- Renewability: Guaranteed renewable to age 75**
- Available riders: Hospital Indemnity and Accidental Death & Dismemberment

Covered conditions

The three benefit categories include:

- **Cancer**
  Carcinoma in situ and cancer (including, leukemia, lymphoma and myeldosplatic syndrome (MDS)).
- **Heart and stroke conditions**
  Heart attack, major organ transplant, stroke, coronary artery bypass surgery, aortic surgery, heart valve replacement/repair surgery and angioplasty.
- **Other Critical Illness conditions**
  Coma (not a result of stroke), end stage renal failure, major organ transplant (other than heart), paralysis (not a result of stroke), blindness, severe burns.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application
- Pre-Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare
- Replacement Notice (if applicable)

The use of a Customer Booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com, or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

*See "Eligible Dependent Children" in the General Information section. Children ages may vary by state, see state-specific charts.
**Subject to the Company's right to increase premiums on a class basis.

Rates

Rates are based on age, gender, tobacco use and coverage type (individual, parent and family), using the issue age of the oldest applicant. If applying for family coverage and either the applicant OR the spouse has used tobacco in the last five years, the tobacco rate must be used.

- Male or female rates are listed for both tobacco and nontobacco usage.
- Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are guaranteed for the initial 12 months.
- The rates include a non-commissionable annual fee of $48.

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Preexisting condition periods may vary by state. Refer to the Exclusions and Limitations in the brochure.

Reduction of benefits

Coverage begins immediately for all illnesses or procedures except for cancer and carcinoma in situ. If cancer or carcinoma in situ are initially diagnosed within the first 30 days immediately following the effective date of coverage, payable benefits will be reduced. The reduced benefit amount for cancer will be 10% of the maximum Critical Illness benefit amount selected. The reduced benefit amount for carcinoma in situ will be 2.5% of the maximum Critical Illness benefit amount selected. After either of these reduced benefit amounts have been paid, the insured's coverage under Category One will end.

Optional benefits

(available for an additional premium)

Hospital indemnity rider

This rider provides a daily cash benefit for hospital confinement as an inpatient due to a covered accident or sickness. We will pay the scheduled Hospital Indemnity benefit for a maximum of 30 days for any one period of confinement. We will pay two times the Hospital Indemnity benefit amount for each day an insured is confined to the intensive care unit as an inpatient. Available daily benefit amounts are between $100 to $1000 (available in $100 dollar increments). Benefit choice must be the same for all insured persons.

Accidental Death & Dismemberment rider

Pays the Accidental Death and Dismemberment Benefit amount when an insured suffers loss of life or dismemberment due to injuries received in a covered accident. The loss must occur no later than 90 days after the date of the covered accident. The total amount payable under this benefit for all losses resulting from any one covered accident shall not exceed the amount payable for loss of life. Available amounts are $25,000, $50,000, $75,000 and $100,000. Benefit choice must be the same for all insureds; however, maximum combined coverage for children will be limited to $25,000.

Type of loss	% Payout
Life	100%
One eye, hand, foot, arm or leg	10%
More than one eye, hand, foot, arm or leg	20%

Underwriting guidelines

Modified guaranteed issue, simplified issue and full underwriting

Modified guaranteed issue (MGI) – For use when writing Groups & Associations with 20 or more applications applying for the base Critical Illness Contract (no riders) with a maximum of $10,000 coverage. In Section 7 of the application, only Part A needs to be completed.

Simplified issue (SI) – For all others applying for the base Critical Illness Contract (no riders) with any coverage amount. In Section 7 of the application, only Part A and Part B need to be completed.

Full underwriting (FUW) – For anyone applying for the base Critical Illness Contract and any riders. In Section 7 of the application, Parts A, B, C & D need to be completed.

Individuals who are currently covered by Supplemental Health Coverage and Title XIX programs (Medicaid, MediCal or any similar name). Be sure to consult the eligibility instructions on the individual state applications for the guidelines and restrictions for coverage in certain states. Please note that the underwriter will make the final determination in all cases.

The medical conditions listed below are not insurable for any coverage:

- Internal cancer
- Blood cancer
- Malignant tumors
- Melanoma
- Carcinoma in situ, not including nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancers including; but not limited to:

- Myelodysplastic syndrome
- Myeloproliferative disorders
- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease

Paralysis including hemiplegia, paraplegia and quadriplegia. Hemiplegia is paralysis that affects only one side of the body.

Muscular abnormalities including, but not limited to, conditions such as amyotrophic lateral sclerosis (ALS or "Lou Gehrig's Disease"); multiple sclerosis; and muscular dystrophy.

Additional underwriting guidelines for simplified issue and full underwriting

The medical conditions listed below are not insurable under simplified issue and full underwriting:

- Acquired immune deficiency syndrome (AIDS)
- Aids related complex (ARC)
- Human immunodeficiency syndrome (HIV)
- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Pulmonary fibrosis
- Pulmonary hypertension
- Chronic bronchitis
- Pulmonary fibrosis
- Pulmonary hypertension

Connective tissue diseases including, but not limited to:

- Cystic fibrosis
- Ehlers-danlos syndrome
- Marfan syndrome
- Osteogenesis imperfecta
- Pseudoxanthoma elasticum (PXE)
- Rheumatoid arthritis
- Scleroderma
- Sjögren's syndrome
- Stickler syndrome

Additional underwriting guidelines for full underwriting

The following occupations are not acceptable for coverage under the Accidental Death & Dismemberment Rider:

- Asbestos and toxic chemical workers (including exterminators)
- Athletes (professional and semi-professional, but excluding golfers and bowlers)
- Aviators and crop dusters
- Bar and tavern owners, bouncers, and bartenders in establishments where greater than 50% of revenues come from liquor sales
- Circus and carnival workers
- Correctional facility workers
- Demolition, explosive and wrecking workers
- Drivers (including explosive haulers, mine and logging drivers, test drivers, race drivers)
- Entertainers, actors, actresses, stunt persons, exotic dancers, models, escort services
- Fishing industry (commercial, not returning to port each night)
- Halfway house workers for alcohol and drug rehabilitation
- Hazardous materials
- Jockeys, horse trainers and wild animal trainers
- Law enforcement and security personnel (field personnel only),
- Fire department workers (including volunteer firemen)
- Logging, mill workers, tree trimmers and tree surgeons
- Massage parlor (excluding licensed massage therapists)
- Meat packers and slaughterhouse workers
- Migrant workers and missionary workers
- Mining, quarry and foundry workers
- Musicians (touring non-classical musicians only)
- Oil rig, natural gas workers, onshore and offshore drilling
- Pyrotechnic technicians
- Rodeo participants
- Structural steel and iron workers and steeple jacks
- Tattoo artist/tattoo parlor owner
- Underwater, tunnel and caisson workers
- Unemployed (including applicants recently laid off, temporarily unemployed, or between jobs)

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-CA-LOYAL) helps agents identify possible uninsurable conditions. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on this application. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.

Height and weight chart

A height and weight chart (see "Cash Advantage® Critical Illness" on page 58) will be used for adults who apply for the Critical Illness policy or any rider offered on the policy.

Persons who become eligible after the effective date

If the policy is issued as individual coverage, there is no coverage for family members. If you marry and wish to provide coverage for your spouse, you must then complete an application and pay the additional premium required for family coverage. If the policy is issued as individual coverage and you wish to add a child(ren) as defined in the policy, you must complete an application for a one parent policy and pay any required additional premium.

Automatic coverage of newborn or adopted child(ren)

Any child born to or adopted by the named insured while the policy is in force as one parent coverage or family coverage is automatically covered from:

- The moment of birth for a newborn child; or
- The earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child.

If the policy is issued as either one parent coverage or family coverage, we do not require an additional premium for such child. The coverage for a newly adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child. Such child is exempt from the waiting period. Coverage will continue for the child unless the placement is disrupted prior to the legal adoption and the child is removed from placement. We must receive written notification within 31 days after the adoption of the child in order to have the coverage continue beyond the 31-day period.

ACCIDENT EXPENSE

Reimbursement benefits to help cover the cost of accident-related expenses

Introduction to Accident Expense

Our Accident Expense Insurance policy is designed to help your customer pay for medical expenses incurred from a covered accident. The selected benefit amount, from $2,500–$25,000, is paid directly to the insured. The amount reimbursed is capped by the annual benefit amount and is paid after meeting the selected deductible and after applying any known major medical network discounts. The base policy also includes a lump sum Accidental Death Benefit and a scheduled Accidental Dismemberment Benefit. Annual deductible choices range from $0–$2,500. The family deductible is two times the individual deductible.*

Basic features

- Issue ages: Birth–74 (available as a child-only policy)
- Available benefit amounts: $2,500–$25,000 (resets each calendar year)
- Deductible amounts: $0–$2,500
- Renewability: Guaranteed renewable to age 80**
- Available riders: Parent Benefit, Catastrophic Accidental Injury, Critical Illness, Declining Deductible & Vehicular Accidental Injury

Accidental Death Benefit

Each policy includes a $25,000 benefit for adults and a $10,000 benefit for children and parents (if the Parent Rider is issued) if death occurs within 90 days as a direct result of covered injuries caused by a covered accident.

Accidental Dismemberment Benefit

Each policy also includes a scheduled benefit amount from $500 to $25,000, depending on the type of covered dismemberment you suffer within 90 days following a covered accident, with no more than two benefit amounts per insured. The initial treatment or medical evaluation for this benefit must occur within seven days of the covered accident.

Covered services

To take advantage of these benefits, the customer must seek initial treatment for the covered accidental injury within seven calendar days and have met their deductible amount selected. Then, the subsequent benefits may be covered, not to exceed the Maximum Annual Benefit Amount selected, which resets yearly.

Covered services include; but not limited to:*

- Ambulance transportation
- Emergency care services
- Drugs
- Tests and x-rays
- Surgery
- Major diagnostic exams
- Durable medical equipment
- Prosthetic devices
- Rehabilitative therapy

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)

*Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.
**Subject to the Company's right to increase premiums on a class basis.

Required forms cont'd

The use of a Customer Booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

Rates

Rates are based on coverage type and issue age. Individual, spouse and child(ren) coverage available. Premiums are age banded for children ages 0–17, ages 18–64 and ages 65–74. Discounted rates are available for individuals with a qualifying Cigna plan (Medical, Med Supp or Med Advantage).

- Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee.

Mode	Bank Draft	List Bill	Direct Bill
Monthly	0.085	0.090	N/A
Quarterly	0.265	0.265	0.265
Semiannually	0.520	0.520	0.520

Optional benefits
(available for an additional premium)

Parent Benefit rider*

Extends the benefits of the base policy to parents or covered spouse's parents. Primary applicant must be between ages 18–64. Parents must between the ages of 40–74 at the time of issue.

Catastrophic Accidental Injury Benefit rider*,**,***

A $25,000 benefit for diagnosis of brain damage, coma, paralysis or severe burns as the result of a covered accident payable once per insured person. Diagnosis must occur within seven days of the covered accident. Covered loss must be within 90 days of the covered accident with a waiting period of 30 days and the injury must be sustained throughout the waiting period.

Critical Illness Benefit rider*,**,***

Provides extra coverage in case of a diagnosis of invasive cancer, a heart attack or stroke. Critical Illness Benefit rider is available for customers from birth to age 70 and provides a lump sum benefit in the amount selected from $10,000 to $25,000 with one critical illness benefit amount eligible per insured person and a 30-day waiting period. Applicant must pass underwriting to qualify for the rider.

*Rider availability varies by state.
**Not available on child-only policies.
***Not available to individuals covered under the Parent Rider.

Declining Deductible Benefit rider

This option can lower the deductible by 25% each calendar year when accident free for at least six months. This rider is available with a selected deductible amount of $100, $250, $500 or $1,000. Stay claim-free and the deductible is reduced by 25% of the original deductible amount for each calendar year that the policy is in force. If there is a claim in a subsequent year, the deductible increases by 25% of the current amount, never to exceed the original deductible amount. Once the deductible reaches zero (after four consecutive years), it will not increase again, even with a claim, while the premium is being paid and the rider is in force.

Vehicular Accidental Injury Cash Benefit rider*,**,***

Provides a one-time lump sum benefit of $1,000 to $5,000 for a covered injury within 30 days of a covered vehicular accident while driving, riding as a passenger in, or getting in or out of, a private passenger automobile, motorcycle or boat. A 90-day waiting period applies from rider inception. Not available for individuals covered under the Parent Rider or to Child-only policies.

Underwriting guidelines

Note: The base policy and all riders, except the Critical Illness Benefit Rider, are guaranteed issue. To qualify for the Critical Illness rider, there are six health questions to complete and underwriting is on an accept or reject basis only.

Critical Illness Benefit rider

The medical conditions listed below are not insurable for any coverage:

- Internal cancer
- Blood cancer
- Malignant tumors
- Melanoma
- Carcinoma in situ, not including nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancers including, but not limited to:

- Myelodysplastic syndrome
- Myeloproliferative disorders
- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders or blood clots:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease

Additional underwriting guidelines for simplified issue and full underwriting

The medical conditions listed below are not insurable under simplified issue:

- Acquired immune deficiency syndrome (AIDS)
- AIDS related complex (ARC)
- Human immunodeficiency syndrome (HIV)

*Rider availability varies by state.
**Not available on child-only policies.
***Not available to individuals covered under the Parent Rider.

FLEXIBLE CHOICE CANCER & HEART

Lump sum benefits to help cover expenses that come from cancer and heart attack, stroke or other heart-related conditions

Introduction to Flexible Choice

Basic features

- Issue ages: 18–99
- Available benefit amounts: $5,000–$100,000 (Must be the same for all insured persons.) See Underwriting Guidelines for any benefit amount over $50,000.
- Renewability: Guaranteed renewable for life*
- Available riders: Lump Sum Cancer, Cancer Recurrence, Lump Sum Heart Attack & Stroke, Heart and Stroke Restoration, Hospital Indemnity, Intensive Care Unit Indemnity, Hospital and Intensive Care Unit Indemnity and Return of Premium.

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Refer to the Exclusions and Limitations in the brochure. May vary by state.

Cancer

(available as a rider on a Heart Attack & Stroke base policy)

Our Flexible Choice Cancer provides a lump sum benefit payable on diagnosis of any cancer. Benefit amounts, ranging from $5,000 to $100,000, are paid directly to the insured or their designee. A Cancer Recurrence Benefit rider and Lump Sum Heart Attack & Stroke rider, along with hospital indemnity riders are also available for an additional premium.

Reduction of benefits

There is a reduced benefit for the first 30 days immediately following the effective date of the policy and/or rider. We will pay 10% of the benefit amount upon diagnosis of cancer. If this reduced benefit is paid, coverage for the insured under the policy will terminate.

Heart Attack & Stroke

(available as a rider on a cancer base policy)

Our Flexible Choice Heart Attack & Stroke Insurance provides a scheduled benefit payable on the first ever diagnosis or procedure under the policy for any of the following qualifying events. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions.

Qualifying events	Percentage of benefit amount payable	
Heart attack	100%	Maximum percentage of benefit amount payable 100%
Heart transplant or combination including heart	100%	
Stroke	100%	
Coronary artery bypass surgery*	25%	
Aortic surgery*	25%	
Heart valve replacement / repair surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*Subject to the Company's right to increase premiums on a class basis.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

› Application

› Pre–Authorized Agreement for EFT (Bank Draft)

› HIPAA Notice

› Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

› Outline of Coverage

› Important Notice To Persons On Medicare (if applicable)

› Replacement Notice (if applicable)

› Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (if applicable)

The use of a Customer Booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

Rates

› Premiums are based on issue age and banded for ages 18–29 and then five-year age bands from ages 30 to 99.

› Rates are unisex and unitobacco.

› Rates are guaranteed for the initial 12 months.

› Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.

› Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

› For proper premium and rating, the oldest applicant must be entered in the primary applicant position. Entering the younger applicant as primary will result in processing delays and required submission of a new, corrected application.

› Cancer Recurrence Benefit rider and Heart Attack & Stroke Restoration Benefit rider amount must match the corresponding base policy amount.

› There is no policy fee or enrollment fee.

› The minimum monthly premium amount is $8.

Mode	Rate
Monthly	1.000
Quarterly	3.118
Semiannually	6.118
Annually	11.765

Direct Bill is not available on a monthly basis.
To calculate the premium for any mode, multiply the monthly premium by the factor.

Optional benefits
(available for an additional premium)

Cancer Recurrence Benefit rider*

Note: Only available on cancer base policy

Pays a percentage of the benefit amount upon additional diagnoses of cancer as shown below. The recurrence benefit applies when 100% of the base benefit has been paid and the customer has not received advice or treatment for cancer for at least 24 consecutive months from the date of the last diagnosis. Up to an additional 100% of the benefit amount is payable under this rider.

Note: Available benefit amounts are between $5,000 and $100,000 and must be the same as the base benefit amount. Benefit choice must be the same for all for all insured persons.

Time period without advice or treatment	Percentage of Recurrence Benefit amount payable for cancer	Maximum percentage of the Recurrence Benefit amount
Less than 24 months	0%	100%
24 months through 5 years	25%	
5 years through 10 years	75%	
More than 10 years	100%	

Heart Attack & Stroke Restoration Benefit rider*

Note: Only available on heart base policy

This rider pays a percentage of the benefit amount upon additional diagnoses or procedure of heart attack, heart transplant, or stroke as shown in the Heart Attack & Stroke base policy table The Restoration Benefit applies when 100% of the original benefit has been paid and the customer has not received advice or treatment from a physician for these specific qualifying events for at least 24 months from the date of the last diagnosis or qualifying event. The customer will receive 25% of the benefit if they have not received treatment for 24 months to five years, 75% for five years to 10 years and 100% after 10 years.

Note: Available benefit amounts are between $5,000 and $100,000 and must be the same as the base benefit amount. Benefit choice must be the same for all for all insured persons.

Hospital Indemnity Benefit rider*

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy, including confinement to the intensive care unit or coronary care unit. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the policy schedule page.**

Intensive Care Unit Indemnity Benefit rider*

Provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the intensive care unit as an inpatient due to injury, sickness, or complications of pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the policy schedule page.**

*Rider availability varies by state.

Optional benefits cont'd

(available for an additional premium)

Hospital and Intensive Care Unit Indemnity Benefit rider*

Cannot be sold with the Hospital Indemnity Rider or the Intensive Care Unit Indemnity Rider

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the Policy Schedule Page.**

Return of Premium rider*

Pays 100% of total premiums paid for the policy and any riders less claims paid upon the death of the primary insured.

Underwriting guidelines

Additional underwriting (including a prescription drug check) and a live phone verification is required on all benefit amounts over $50,000. Amounts under $50,000 will be at the discretion of the underwriter. A maximum $100,000 benefit will be issued across all companies for our lump sum policies. **The underwriter will make the final determination in all cases.**

Medical conditions including; but not limited to, those listed below are not insurable for any coverage:

- Acquired immune deficiency syndrome (AIDS)
- AIDS related complex (ARC)
- Human immunodeficiency syndrome (HIV)

Cancer

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years:

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including; but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative Disorders; including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

*Rider availability varies by state.

Heart Attack & Stroke

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots; including but not limited to:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease
- Pulmonary hypertension

Diabetes associated with insulin use (excluding gestational diabetes), neuropathy or retinopathy.
High blood pressure for which three or more medications have been taken concurrently.

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied.

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on this application. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.

Height and weight chart

A height and weight chart (see "Flexible Choice" on page 58) will be used for adults who apply for the Heart Attack & Stroke base policy/rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider. This chart will also be used when the above riders are applied for under the Flexible Choice Cancer product.

CANCER TREATMENT

Benefits that help cover the cost of care and treatment of cancer

Introduction to Cancer Treatment

Our Cancer Treatment Insurance policy pays your customer the benefit amount for the care and treatment of cancer from the coverage level they select. The cancer must be diagnosed after the waiting period has expired. Please refer to the Cancer Treatment Benefit Chart in the brochure for specific benefits, amounts and limits.

Basic features

- Issue ages: 18–99
- Renewability: Guaranteed renewable for life*
- Available riders: Lump Sum Cancer, Lump Sum Heart Attack & Stroke, Hospital and Intensive Care Indemnity, Hospital Indemnity, Intensive Care Unit Indemnity and Return of Premium

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Refer to the Exclusions and Limitations in the brochure. May vary by state.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (if applicable)

The use of a customer booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

Rates

- Premiums are based on issue age and banded for ages 18–24 and then five-year age bands from ages 25 to 99.
- Rates are unisex and unitobacco
- Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- For proper premium and rating, the oldest applicant must be entered in the primary applicant position. Entering the younger applicant as primary will result in processing delays and required submission of a new, corrected application.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee.

Mode	Rate
Monthly	1.000
Quarterly	3.118
Semiannually	6.118
Annually	11.765

To calculate the premium for any mode, multiply the monthly premium by the factor

*Subject to the Company's right to increase premiums on a class basis.

Optional benefits
(available for an additional premium)

Lump Sum Cancer rider*

The Lump Sum Cancer Rider provides 100% of the selected benefit amount payable to the insured customer upon the first ever diagnosis of invasive cancer or carcinoma in situ. If the insured is diagnosed within the first 30 days immediately following the effective date of the rider, the benefit amount payable will be reduced to be 10% of the selected benefit amount and coverage for that insured person will be terminated. Available benefit amounts are between $5,000 and $100,000. Benefit choice must be the same for all for all insured persons.

Lump Sum Heart Attack & Stroke rider*

Our Lump Sum Heart Attack & Stroke rider provides a scheduled benefit payable on the first ever diagnosis or procedure under the policy for any of the following qualifying events. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions.

Qualifying events	Percentage of benefit amount payable	
Heart attack	100%	Maximum percentage of benefit amount payable 100%
Heart transplant or combination including heart	100%	
Stroke	100%	
Coronary artery bypass surgery**	25%	
Aortic surgery**	25%	
Heart valve replacement/repair surgery**	25%	
Angioplasty**	10%	
Stent**	10%	

Hospital and Intensive Care Unit Indemnity Benefit rider*

Cannot be sold with the Hospital Indemnity rider or the Intensive Care Unit Indemnity rider

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness, complications or pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the policy schedule page.**

Hospital Indemnity Benefit rider*

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a Hospital as an inpatient due to injury, sickness, complications or pregnancy, including confinement to the intensive care unit or coronary care unit. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the policy schedule page.**

*Rider availability varies by state.
**Payable only once in an insured person's lifetime.

Intensive Care Unit Indemnity Benefit rider*

Provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the intensive care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each Insured Person will be reduced by fifty percent (50%) as shown on the Policy Schedule Page.**

Return of Premium Upon Death rider*

Pays 100% of total premiums paid for the policy and any riders less claims paid upon the death of primary insured.

Underwriting guidelines

Please note that the underwriter will make the final determination in all cases.

Medical conditions including; but not limited to, those listed below are not insurable for any coverage under the base policy and riders:

- Acquired immune deficiency syndrome (AIDS)
- Aids related complex (ARC)
- Human immunodeficiency syndrome (HIV)
- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including; but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders; including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied. Additional underwriting (including a prescription drug check) and a live phone verification is required on all benefit amounts over $50,000 and at the discretion of the underwriter on amounts of $50,000 and under. A maximum $100,000 benefit will be issued across all of our policies and companies.

Lump Sum Cancer rider

Medical conditions including; but not limited to, those listed below are not insurable for any coverage under the base policy/rider:

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including; but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders; including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

*Rider availability varies by state.

Underwriting guidelines cont'd

Lump Sum Heart Attack & Stroke rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots; including but not limited to:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease
- Pulmonary hypertension

Diabetes associated with insulin use (excluding gestational diabetes), neuropathy or retinopathy.
High blood pressure for which three or more medications have been taken concurrently.

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on this application. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.

Height and weight chart

A height and weight chart (see "Cancer Treatment" on page 58) will be used for adults who apply for the Heart Attack & Stroke rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider.

ACCIDENT TREATMENT

Benefits that help cover the cost
of care and treatment of an accident

Introduction to Accident Treatment

The Accident Treatment Insurance policy pays your customer a fixed amount for the expenses they incur from an accident. The policy provides a predetermined benefit amount based off of a benefit schedule that can be found in the brochure. Covered benefits can be categorized into the following: Accidental Injuries; Hospital and Services & Accidental Death & Dismemberment.

Basic features

- Issue ages: 18–74
- Available benefit amounts: Basic, Plus, Enhanced (scheduled amounts vary by tier, but the list of covered benefits is consistent across all levels. Tier selection be the same for all insured persons.)
- Renewability: Guaranteed renewable to age 80*
- Available riders: Lump Sum Cancer, Lump Sum Heart Attack & Stroke, Hospital and Intensive Care Indemnity, Hospital Indemnity, Intensive Care Unit Indemnity and Return of Premium

Preexisting conditions for riders

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition under any applicable rider coverage. Refer to the Exclusions and Limitations in the brochure.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (if applicable)

The use of a customer booklet is required in all states. Please consult with the Supply Department at CSBSupplies@Cigna.com or visit AgentView for the proper Customer Booklet form for the appropriate state. Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare is required only if Medicare eligible.

*Subject to the Company's right to increase premiums on a class basis.

Rates

Premiums are based on occupation class and issue age. Please refer to our Accident Treatment Occupation Guide (LOYAL-5-0016) for occupation classification. Premiums are banded for ages 18–24 and then five-year age bands from ages 25 to 70+.

- Four modes of premium payment are available: Annual, semiannual, quarterly and monthly. Monthly is available only via bank draft and list bill. Quarterly, semiannual and annual are available via bank draft or direct bill.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- For proper premium and rating, the oldest applicant must be entered in the primary applicant position. Entering the younger applicant as primary will result in processing delays and required submission of a new, corrected application.
- Rates are unisex and unitobacco.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee

Mode	Rate
Monthly	1.000
Quarterly	3.118
Semiannually	6.118
Annually	11.765

To calculate the premium for any mode, multiply the monthly premium by the factor

Optional benefits

Available for an additional premium. Some riders are underwritten and have qualifying health questions listed on the application.

Lump Sum Cancer rider

The Lump Sum Cancer rider provides 100% of the selected benefit amount payable to the insured customer upon diagnosis of invasive cancer or carcinoma in situ. If the insured is diagnosed within the first 30 days immediately following the effective date of the rider, the benefit amount payable will be reduced to be 10% of the selected benefit amount and coverage for that insured person will be terminated. Available benefit amounts are between $5,000 and $100,000. Benefit choice must be the same for all for all insured persons.

Lump Sum Heart Attack & Stroke rider

Our Lump Sum Heart Attack & Stroke rider provides a scheduled benefit payable on the diagnosis or procedure under the policy for any of the following qualifying events. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions.

Qualifying events	Percentage of benefit amount payable	
Heart attack	100%	Maximum percentage of benefit amount payable 100%
Heart transplant or combination including heart	100%	
Stroke	100%	
Coronary artery bypass surgery**	25%	
Aortic surgery**	25%	
Heart valve replacement/repair surgery**	25%	
Angioplasty**	10%	
Stent**	10%	

*Rider availability varies by state.
**Payable only once in an insured person's lifetime.

Hospital and Intensive Care Unit Indemnity Benefit rider

Cannot be sold with the Hospital Indemnity rider or the Intensive Care Unit Indemnity rider

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness, complications or pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each Insured Person will be reduced by fifty percent (50%) as shown on the Policy Schedule Page.**

Hospital Indemnity Benefit rider

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a hospital as an inpatient due to injury, sickness, complications or pregnancy, including confinement to the intensive care unit or coronary care unit. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the Policy Schedule Page.**

Intensive Care Unit Indemnity Benefit Rider

Provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the Intensive Care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours and benefits will not be payable for more than 30 days for any one period of confinement. **Upon attainment of age sixty-five (65), coverage for each insured person will be reduced by fifty percent (50%) as shown on the Policy Schedule Page.**

Return of Premium Upon Death rider

Pays 100% of total premiums paid for the policy and any riders less claims paid upon the death of the primary insured.

Underwriting guidelines

The base policy is guaranteed issue. Please refer to our Accident Treatment Occupation Guide (LOYAL-5-0016) for occupation classification. **The underwriter will make the final determination in all cases, including occupational class rating.**

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied. Additional underwriting (including a prescription drug check) and a live phone verification is required on all benefit amounts over $50,000 and at the discretion of the underwriter on amounts of $50,000 and under. A maximum $100,000 benefit will be issued across all of our policies and companies.

Medical conditions including; but not limited to, those listed below are not insurable for any coverage:

- Acquired immune deficiency syndrome (AIDS)
- AIDS related complex (ARC)
- Human immunodeficiency syndrome (HIV)

Underwriting guidelines cont'd

Lump Sum Cancer rider

Medical conditions including; but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include nonmelanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including; but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative Disorders; including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Lump Sum Heart Attack & Stroke rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots; including but not limited to:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia
- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease
- Pulmonary hypertension

Diabetes associated with insulin use (excluding gestational diabetes), neuropathy or retinopathy.
High blood pressure for which three or more medications have been taken concurrently.

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions. We will **require a signed and dated letter** from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is **not** listed on this application. This letter **must** state the condition for which the medication is being taken **and** must state that the applicant does not have the declinable condition on this list. Failure to include this letter **with** the application may lead to the declination of the application.

Height and weight chart

A height and weight chart (see "Accident Treatment" on page 58) will be used for adults who apply for the Heart Attack & Stroke rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider.

GENERAL INFORMATION

General information

New business guidelines

- Additional underwriting (including a prescription drug check) and a live phone verification is required on all benefit amounts over $50,000 and at the discretion of the underwriter on amounts of $50,000 and under. A maximum $100,000 benefit will be issued across all of our policies and companies.
- You must be licensed with a resident or nonresident license in the state where the applicant resides. You must use the application based on the applicant's resident state. Applications received based on the agent's resident state will be returned.
- Make sure to complete all sections of the application for the requested coverage.
- All applications must be signed by the policy owner. A power of attorney (POA) is not acceptable, except for OE/GI cases. Proof of POA is required. If any other applicants have assigned a POA to another individual and the POA is currently relied upon for handling the financial affairs of the applicant, then such applicant is not eligible for coverage. (A Phone Verification acts as a wet signature when selling over the phone or using **EXPRESS APP** (see "EXPRESS APP" on page 53.)
- Your signature and assigned agent number must be included in the space provided on the application for the agent's information.
- If it is necessary to correct a mistake on the paper application, both you and the applicant must initial the strikeover and this must be done in the presence of the applicant. Do not use white-out or correction fluid on the application.
- Applications must be received within 30 calendar days of date signed if you are appointed with the company in the state of issue. If you are not yet appointed with the company in that state, you must submit the application immediately.
- The effective date cannot be day 29, 30 or 31 of the month. If the application is dated one of these dates, the effective date will be the first of the following month.
- Coverage does not begin until the effective date of the policy. Only losses incurred on or after the effective date of the policy will be considered under the terms and conditions of the policy.
- If two applications for the same product are submitted at the same time on the same person, the one with the earliest application date will be processed and the other will be withdrawn. Initial full modal premium must be submitted with all applications (except for faxed and **EXPRESS APP** applications where the bank draft authorization can be completed for premium).
- Due to the USA Patriot Act's broad anti-terrorism measures, CSB's policy is to prohibit money laundering through detection, deterrence and prevention. Therefore, we do not accept currency (cash), foreign currency, Cashier's checks, money orders or Traveler's checks as premium payments. A check drawn on the payer's own account, such as a personal check, is not considered cash. Third-party checks/payments and/or representative payees are not acceptable for payment of any premium, unless Group/Association Direct/List Bill status is utilized.

New business submission

All products in this guide may be submitted:

- Online via **EXPRESS APP**, our web-based application tool
- Fax via our FaxApp Program (see "FaxApp Program" on page 53.)
- Standard mail, wet signature required

EXPRESS APP

EXPRESS APP is a 100% online application process that makes submitting new business fast and easy. Go to **AgentViewCigna.com** and select the **EXPRESS APP** tab to get started.

Get quotes

› You will need your customer's age or date of birth, tobacco status, gender and zip code in order to receive a Quick Quote. Annual, semiannual, quarterly and monthly premiums for all available plans in your state will display within seconds. Use the Family Quote to quote couples or families.

› Search our Declinable Drug List by typing in the letters or words of a drug or drug-related condition.

Send proposals

› Click on the Send Forms button to securely email a proposal to your customer. To send proposals and email confirmations, your customer must first consent to receive documents electronically.

› Click the Send Forms button to open the consent window and follow the instructions

Apply

› Once you have selected the desired products, tabs will appear that contain the application portion. Fill out information in all areas and tabs. We will gather electronic signatures during the Phone Verification (PV).

› **EXPRESS APP** will automatically check for missing information and prompt you to correct the errors.

› If you enter an email address to send the customer copies of the application and other required forms, the consent window will open when you submit the application and you will be prompted to complete the information and obtain the customer's acknowledgement.

Note: When completing a Critical Choice application, **EXPRESS APP** may show a decline without specifying which question has triggered the decline. We recommend removing riders, if selected, to find the decline. If this does not clear the decline, please create a separate app for each customer in order to find the decline.

Submit

› After you have input all of the customer's information, take time to go over it once more with them. After you have verified that all of the information is correct, go to the Review & Accept page and complete the required information, then click Accept.

› Once submitted, you and the applicant will receive a copy of the application and Outline of Coverage, If Medicare eligible, the applicant will also receive the Guide to Health Insurance for People with Medicare via email. (Select states must consent to receive as noted above.)

EXPRESS APP for iPad

The convenience and functionality of **EXPRESS APP** have been rolled into a mobile application that provides everything you need to quote, sell and submit applications right from your iPad!

Download Instructions

› From your iPad, visit agentmobilesupport.com/ExpressApp/ and click on the download button. **Note:** This download link will not work from your desktop browser.

› Click Install when prompted.

› Activate app (optional).

Activation

On startup, the application will prompt you for your **EXPRESS APP** ID and Activation Code. This is a one-time activation process. To retrieve your Activation Code, log in to AgentView, then click on the link to **EXPRESS APP**. **Note:** EXPRESS APP **is not available for under 65 (disabled) applications.**

FaxApp Program

Submit applications via fax with our FaxApp Program. Just fill out the FaxApp Cover Sheet (CSB-9-0009), as seen on the following page, and fax it, along with the application and all supporting documents to 877.704.8186. A case number will be assigned and the application will be processed. Your commission is generated the day after issue.

FaxApp cover sheet

NEW BUSINESS SUBMISSION FORM/FAXAPP

To: Cigna Supplemental Benefits **Fax #: 877-704-8186**

AGENT INFORMATION *(Required)*

FROM:	
PHONE #:	**FAX #:**
WRITING #:	**EMAIL:**
DATE:	**NUMBER OF PAGES:** **+ cover**

APPLICANT INFORMATION *(Required)*

NAME:	**SS#:**	**☐ Combo ☐ CWA ☐ Draft**
NAME:	**SS#:**	**☐ Combo ☐ CWA ☐ Draft**
NAME:	**SS#:**	**☐ Combo ☐ CWA ☐ Draft**
NAME:	**SS#:**	**☐ Combo ☐ CWA ☐ Draft**
NAME:	**SS#:**	**☐ Combo ☐ CWA ☐ Draft**

All applications submitted with a single cover sheet must be from the same writing agent.

PROCEDURES

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.**

Simply complete the application, and fax the following to **877.704.8186**.

- FaxApp cover sheet
- Application in numeric page order
- Any state-specific or replacement forms, if applicable
- Copy of the initial premium check, if collected from the customer at the point of sale

Medicare supplement under age 65 (disabled) cases are not eligible for the FaxApp Program. You must mail the completed application with a check for the first month's premium to the Imaging – New Business address below.

PREMIUM

- Agents are encouraged to utilize the Bank Draft Authorization form to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant, **please indicate the case number on the check** and mail the check, stapled to the top of the FaxApp cover sheet, to:

Imaging – New Business
PO Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating that the contract will be cancelled in 5 days, unless we receive payment for the issued contract. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the policy has been cancelled due to non-payment of premium.**

Cigna®

Phone Verification (PV)

A Phone Verification (PV) is a phone interview that applicants must complete in order for CSB to process applications. The PV acts as an electronic signature and verifies medical questions with the applicant. Completing the PV at the point of sale, not only processes applications faster, it also helps you get paid faster. Refer to the chart below for PV availability. A PV associate is available to take live PV calls Monday–Friday from 8:00 am to 6:00 pm (CT) at **866.825.4822**.

Product		EXPRESS APP (no wet signature)	Phone/fax (no wet signature)	Paper/fax (with wet signature)
Medicare Supplement	OE/GI	Not needed*	Live PV	Not needed*
	Underwritten	Live PV	Live PV	Live PV
Companion Whole Life		Live PV	Live PV	Live PV
Cancer, Heart Attack & Stroke, Critical Illness and Accident		Not needed**	Live PV	Not needed
Individual Whole Life		Live PV	Live PV	Live PV

*Applicant verification in lieu of a PV.
**Flexible Choice over $50,000 require live PV.

Tips for completing the PV

› Make sure you have completely filled out the application prior to calling our PV line. This includes going over the entire application, if conducting the sale over the phone or using **EXPRESS APP**.

› You (the agent) may initiate the PV call; however, the applicant must personally answer all questions. If the PV call is not initiated at the time of sale, it is your responsibility to make arrangements for the applicant to call as soon as possible.

› If the applicant completes the PV on their own, make sure they have:

- The plan they have chosen and the proposed rate
- A list of their prescription medications

› The PV will confirm that the applicant received the following:

- Copy of the Application (if applying for Medicare Supplement)
- Copy of the Outline of Coverage
- The Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare Guide
- Any state required forms

The PV cannot be conducted if the applicant does not have all of the above information. The approximate length of the interview is five minutes. For Medicare Supplement, the interview is about 15 minutes. Usual and customary underwriting procedures will remain in place.

Case number

Prior to completing the PV, the applicant will receive a PV case number that must be included on the app before submitting.

Multiple applicants

When an agent calls in requesting the PV, if both spouses are applying and available, the phone interviewer will conduct one interview, asking the questions one time and having both applicants respond to each question. This procedure could reduce the PV time for both applicants by about 20 minutes. No questions are asked regarding over-the-counter drugs. Outbound calls can only be conducted as one interview if there is a notification of both spouses applying on the application(s).

New business processing

Delivery receipts (in states where required)

For policies that are hand-delivered by the agent to the customer:

› The agent should explain all the provisions and benefits to the customer, and once completed, the delivery receipt should be signed and dated by the customer and the agent.

› Return to the administrative office only if required by your state. The agent should keep a copy for his or her records.

› The agent should deliver policies within seven days of receipt.

Failure to submit the delivery receipt back to the administrative office will not result in the cancellation of the policy. In some states, this receipt is intended to protect the agent with proof of delivery. In other states, the receipt is required.

Declined applications

If a customer's circumstances fall outside of our limits of insurability, he or she will be notified of the decline in the form of a letter. This letter will identify the specific reasons for the decline. This letter is mailed to the applicant and agent.

Appealing a declined application

We will **require a signed and dated letter** from the treating physician for any appeal, based upon a declinable medication or in-house claims history, as stated above. The agent should contact the underwriter to determine what will be required with all **other** declines.

Appeals should be faxed to 855.239.8763, Attn: Underwriting. Please include the assigned application number on the fax cover page.

Note that the underwriter will make the final determination in all cases.

Recent surgical procedures

We will **require a signed and dated letter** from the treating physician if the applicant has had a surgical procedure within the past 90 days; or 30 days for cataract surgery. This letter **must** state that the applicant has **completed** the requisite follow-up visits and therapy, and has been released from the doctor's care. Failure to include this letter **with** the application may lead to the declination of the application.

Note that the underwriter will make the final determination in all cases.

Incomplete applications

If there is insufficient information on the application, we will contact the agent during the application process to obtain information. If the information is not received within 30 calendar days, the application is terminated as incomplete and a letter sent to the applicant and agent. Any refund of premium will be returned to the applicant.

Applications with premium shortages

Applications submitted with premium shortages will be processed with the following guidelines:

Premium shortage	Guidelines
Up to $10.00	Policy will be issued with shortage amount taken from agent's commissions (in this case the agent is expected to collect shortage amount from customer) or via bank draft.
$10.01 or more	Policy will be issued with a coupon, which is a requirement of additional premium due. Notification of this action will be mailed with the policy to the agent. If the additional premium is not received within 45 days, the policy will be terminated and the initial premium refunded to applicant.

Height and weight charts

Medicare Supplement and Companion Whole Life

Applicants whose weight is outside the limits in the build chart may be insurable in the Medicare Supplement Standard II or Standard III class if available in your state.

Female				Male		
Minimum weight for Preferred and Standard classes	Maximum weight for Preferred and Standard classes	Maximum weight with selected conditions	Height	Minimum weight for Preferred and Standard classes	Maximum weight for Preferred and Standard classes	Maximum weight with selected conditions
77	158	145	4'6"	85	166	149
80	163	150	4'7"	88	172	155
83	169	155	4'8"	91	178	160
86	176	161	4'9"	95	185	166
89	181	166	4'10"	98	191	172
92	188	172	4'11"	101	198	178
95	195	179	5'0"	105	205	184
98	201	185	5'1"	108	212	191
101	208	191	5'2"	111	219	197
104	215	197	5'3"	114	226	203
108	221	203	5'4"	119	233	209
111	228	209	5'5"	122	240	216
115	236	216	5'6"	127	248	223
118	242	222	5'7"	130	255	229
122	250	229	5'8"	134	263	236
125	257	236	5'9"	138	271	244
129	265	243	5'10"	142	279	251
133	273	250	5'11"	146	287	258
136	280	257	6'0"	150	295	265
140	288	264	6'1"	154	303	272
144	296	272	6'2"	158	312	280
148	304	279	6'3"	163	320	288
152	313	287	6'4"	167	329	296
156	320	294	6'5"	172	337	303
160	329	301	6'6"	176	346	311
164	337	309	6'7"	180	355	319
168	346	317	6'8"	185	364	327
173	354	325	6'9"	190	373	335
177	364	334	6'10"	195	383	344
181	372	341	6'11"	199	392	352

Note: If the customer's height is not included on the chart please call underwriting at 866.825.4822.

Selected conditions include tobacco use, diabetes or maintenance medications for heart and vascular conditions. Applicants with one of the selected conditions whose weight is greater than the maximum weight in the "Maximum weight with selected conditions" column may qualify for the Standard II or Standard III class. Check your state's Outline of Coverage or our Product Availability chart for availability.

Critical Choice
Cancer and Heart Attack & Stroke

Cash Advantage®
Critical Illness

Female		Height (ft./in.)	Male	
Min. weight (lb.)	Max. weight (lb.)		Min. weight (lb.)	Max. weight (lb.)
77	158	4'6"	85	166
80	163	4'7"	88	172
83	169	4'8"	91	178
86	176	4'9"	95	185
89	181	4'10"	98	191
92	188	4'11"	101	198
95	195	5'0"	105	205
98	201	5'1"	108	212
101	208	5'2"	111	219
104	215	5'3"	114	226
108	221	5'4"	119	233
111	228	5'5"	122	240
115	236	5'6"	127	248
118	242	5'7"	130	255
122	250	5'8"	134	263
125	257	5'9"	138	271
129	265	5'10"	142	279
133	273	5'11"	146	287
136	280	6'0"	150	295
140	288	6'1"	154	303
144	296	6'2"	158	312
148	304	6'3"	163	320
152	313	6'4"	167	329
156	320	6'5"	172	337
160	329	6'6"	176	346
164	337	6'7"	180	355
168	346	6'8"	185	364
173	354	6'9"	190	373
177	364	6'10"	195	383
181	372	6'11"	199	392

Flexible Choice

Used when any of the following are applied for: Heart Attack & Stroke base policy/rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider. This chart will also be used when the above riders are applied for under the Flexible Choice Cancer product.

Cancer Treatment
Accident Treatment

Used when any of the following riders are applied for under either product: Heart Attack & Stroke rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider and Intensive Care Unit Indemnity Benefit rider.

Female and Male	
Height (ft./in.)	Weight (lb.) (not more than)
4'8"	190
4'9"	198
4'10"	205
4'11"	211
5'0"	219
5'1"	226
5'2"	233
5'3"	240
5'4"	247
5'5"	252
5'6"	258
5'7"	262
5'8"	269
5'9"	279
5'10"	289
5'11"	300
6'0"	311
6'1"	319
6'2"	326
6'3"	333
6'4"	338
6'5"	343
6'6"	351
6'7"	358

The above charts assume the applicant's other health history is acceptable. If this is not true, the above may not apply.

Customer services

MyPolicyHQ.com

Customers have online access to their policy and coverage details on MyPolicyHQ.com. It's one place to keep track of claims, less paper to deal with and an easy way to access their account. Customers can:

- Access policy coverage
- Set up automatic premium payments
- Print temporary ID cards
- Update their address
- Review EOBs
- Review claim payments

Eligible dependent children

Child(ren) means your natural child, stepchild, legally adopted child, a child placed with you for adoption, a foster child, or court-appointed guardianship/order/administrative order for a child including grandchild, who is:

- Insurable and named on the application;
- Unmarried;
- Chiefly dependent on you or your spouse for support; and
- Has not attained the limiting age of 19 or 26 if enrolled as a full-time student in an accredited school or college. (Ages may vary by state.)

Child(ren) also includes dependent child(ren), regardless of age, who:

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

When a spouse or dependent child is no longer eligible for coverage, a new application must be submitted and the applicant must go through full underwriting.

For all other products, dependents that are no longer eligible for coverage (due to age, etc.), must complete a new application and go through underwriting.

Beneficiary change

To change a beneficiary designation or to designate a new beneficiary, a Beneficiary Designation Form (CSB-11-0010BDF) must be completed and signed. The full name of the beneficiary, date of birth, Social Security number, address and relationship to the insured must be stated on the form. The form must be signed by the primary insured and dated.

Name change

To change the name of the insured, a Relationship Change and Designation Form (CSB-11-0010RCDF) must be completed and signed. The full name of the insured must be shown on the form. The form must be signed by the primary insured and dated. The insured will need to send a copy of updated identification such as driver's license, Social Security card or marriage certificate.

Electronic funds transfer/bank draft authorization change

To change the mode on a policy from direct billing to a bank draft, a Pre-Authorization for electronic funds transfer form (CSB-9-0035-EFT) must be completed. The bank account number and routing number for the bank must be stated. The bank account holder must sign the form exactly as the signature appears on bank records. Also, a blank personal check with the word "void" across the face of the check must accompany the completed and signed authorization.

Addition/deletion of dependents

To add or delete a dependent, a new application is required, signed by the policy owner. Mark "Contract Change" from the options at the top of the application. If adding a dependent, the full name, date of birth, sex and relationship to the primary insured must be indicated and the medical questionnaire on the application must be completed. When we receive the completed form, it will be sent to our underwriting department for review. All final decisions on a dependent's eligibility will be determined by underwriting. Upon approval, the dependent will be added effective as of the next premium due date after the date of the approval. The increased premium will be billed or drafted at that time.

For deletion of a dependent, the name of the dependent and the reason for deletion must be indicated on the application. There is no need to answer the medical questions, as they are not applicable. Upon receipt of the completed application, the dependent will be removed from coverage and the premium will be adjusted accordingly.

Verification of dependent status

Please contact our customer service department to determine if the child can continue dependent coverage as a full-time student. To verify full-time student status, we will need a copy of the school transcripts in order to continue coverage. (Ages may vary by state.)

Increase/decrease in coverage

For an increase in coverage, a new application is required and should be signed by the primary insured. Mark "Benefit Change" from the options at the top of the application and complete the Benefit Selection and Medical Questions. This will be forwarded to our underwriting department for review. Our underwriting department will make all final decisions for any benefit increase. Upon approval of the increase, the benefits will be added effective as of the next premium due date after the date of approval. The increased premium will be billed or drafted at that time.

For a decrease in coverage, a Contract Service form (CSB-11-0010PSF) is to be submitted and the Special Request field completed indicating the coverage change. The coverage will be decreased and the premium adjusted accordingly.

Reinstatements

When a policy lapses, a new application, signed by the primary insured, is required for reinstatement of the policy. Mark "Reinstatement" from the options at the top of the application, complete the medical questions and return to the underwriting department at the address indicated below.

The application must be received within 30 days of the signed date on the form.

A policy within 90 days of a lapse date will be reinstated and back premiums must be paid. After the 90 days, a new application would be required. (Some exceptions may apply depending on policy language.)

If the policy is approved for reinstatement, it will be reinstated with the same policy number. A letter will be sent from customer service stating that the reinstatement has been approved and indicating the amount of premium due. Do not submit monies with the completed application.

If the reinstatement is declined, a letter will be sent from underwriting to the customer with the reason(s) why the policy was not reinstated.

Contact customer service at 877.454.0923, or submit request for reinstatement and completed applications to:

Cigna Supplemental Benefits
PO Box 26580 | Austin, TX 78755-0580
Fax: 888.670.0146 | CSBSupport@Cigna.com

Bank draft/auto-pay

Checking account set up

If the monthly (bank draft/auto-pay) method of payment is chosen from a checking account, complete the entire electronic funds transfer agreement in the application packet and obtain the signature of the person who will assume financial responsibility for the policy. If the applicant is under 65, you must mail the application and attach a check for the first month's premium. If faxing, attach a voided check of the account that will be drafted with the FaxApp cover sheet (see "FaxApp cover sheet" on page 54.) Include the bank routing number and account number, as we cannot process the application without this information.

Savings account set up

If the monthly (bank draft/auto-pay) method of payment is chosen from a savings account, we must have proof of the account number written in the bank draft authorization section. If mailing or faxing the application, you must send a deposit slip for verification of the account. The applicant should obtain, from their bank, the appropriate routing number to draft from a savings account as the routing number listed on the savings account deposit slip may not be correct. Mark through the routing number on the deposit slip and write in the correct routing number for withdrawals, as provided by the bank. We cannot process the application without this information.

If submitting multiple applications please make sure that **each** application has the bank information completed and signed by the person responsible for payment. **Each** application must also have a voided check for checking accounts or a deposit slip for a savings account attached.

Bank draft dates

The bank draft date can be different from the effective date. The draft can be set up for any day of the month between 1 and 28. If no draft date is indicated on the application, the drafts will occur on the same day of each month that corresponds with the requested effective date. For example, if the policy is effective on April 15, the policy will draft each month on day 15.

Commissions

Advances

If approved by your upline and the Company, advance commissions may be available. Advance commissions on newly issued business will be credited to your account on a daily basis. Advances are paid via direct deposit into the account we have on file for that agent. We will only advance commissions when the initial premium is paid via monthly bank draft/EFT or the customer's personal preprinted check. We will not advance commissions for business written on family members.

Earned first year and renewal commissions are credited to your account on a biweekly basis. You can find the schedule for biweekly commission statements on AgentView (Agency Management > Commissions).

Advances are paid in increments of six, nine or 12 months. For Medicare Supplement, advances are paid in increments of six, nine, 12 and 15 months. Interest is charged on all secured advance balances from inception until they are paid off. An advance balance for an in-force policy (secured advance balance) is paid off by commission earned on that specific policy. Once the advance balance is paid off, future earned commissions are payable to the agent. If the advance balance becomes unsecured (the policy lapses, etc.) then the advance balance record is changed to an unsecured advance balance. These unsecured balances are paid off by holding 100% of all commissions payable (new advances as well as earned first or renewal commissions) until recovered. CSB reports only earned commissions as taxable amounts on agent 1099's.

Note: The maximum advance on Whole Life is $1,500 per policy. Remember, if death occurs in year one, we will do a full charge back on the policy. This will result in a commission reversal. Please refer to your commission schedule for information about commission reversals and charge backs.

If you have any questions about your commissions, you can contact Commissions at 877.454.0923.

Agent services

AgentView

AgentView (**AgentViewCigna.com**) gives you the tools to effectively manage your business. All business and customer service forms are available on AgentView. You can also download applications, track your business, view commission statements and much more.

To create an account:

› Fill out the Create an Account section with your username and password.

› Fill out the Personal Information section with your email address, first and last name and Social Security number.

› Fill out the Security Information section by answering the four security questions.

› Lastly, fill out the Eligibility Verification section with your agent number and zip code.

Note: If you are registering a corporate tax ID number or agency, please enter the last name and Social Security number of the principal and add "SYS" to the front of the writing number. If you need assistance registering for or logging in to the website, please contact our Agent Resource Line at 877.454.0923.

Agent notices

Many email communications and agent notices are sent on a weekly basis to give you the most up-to-date information. A current and correct email address is necessary to receive agent notices as well as obtain email confirmations when you submit business to us. To update your email address and other contact information, contact the Licensing Department at CSBLicensing@Cigna.com.

Advertising review and approval

All advertising materials including print, email, websites, presentations, etc., regardless of whether its purpose is for consumers or agents, must be approved by our Compliance and Marketing Departments prior to use. Anything intended to generate public interest in an insurance product, company or agent is considered to be advertising. There are two ways to receive approval of your personal advertising using any of our company names, logos or products:

› If you have created an advertisement, submit a copy of the ad for prior approval by completing an Advertising Material Review Request Form (CSB-9-0024, found on AgentView). You can obtain this form and complete advertising guidelines on AgentView under Business Building > Creating Ads.

› If you are interested in one of our pre-approved advertising materials, you can refer to the CSB Prospecting Portfolio (CSB-9-0031) for a variety of advertisements for Medicare Supplement only. The CSB Prospecting Portfolio can also be found on AgentView under Business Building > Creating Ads.

Once you submit/select your advertisement

Allow a minimum of five business days for the Compliance Department to review the advertisement.

› CSB will contact the agent with approval of the advertisement or notification of changes that must be made to comply with advertising policy and regulations. Please note that many advertising pieces will also require approval by the applicable state department of insurance.

› In order for any previously disapproved advertising material to be considered further, it must be resubmitted to the Home Office with all of the necessary revisions.

› Once an advertising piece is approved, the Compliance Department will assign an advertisement form number, which must be included in the advertisement. **This approval is good for a period of six months.** Any subsequent use of the advertisement after this period must be resubmitted for approval.

For more information about our advertising policies, please call our Compliance Department at 877.454.0923 ext. 8074794.

Group/Association

All supplemental products are eligible under a Section 125 Cafeteria Plan, however, the Return of Premium Rider and the Cash Value Rider cannot be offered under a Section 125 Cafeteria Plan.

Setting up your group/association

Fax the "Group/Association Setup Form" to the Group/Association Case Coordinator at 512.467.7403 or email forms to CSBNewBusiness@Cigna.com.

If approved, you will be assigned a CSB Group Number and must then:

› Fill out the appropriate application for each member (Note: Franchise Application required for Ohio); and

› Include the assigned CSB Group Number on every application and cover sheet and fax to the Group/Association Case Coordinator. Note: If paying via list bill, you must also include the Payroll Deduction Form.

Note: You must wait until you get all of the applications before sending them to the Group/Association Case Coordinator.

If customers are paying their premium via bank draft or direct bill, you are finished. If paying via list bill, you must:

› Make a copy of all of the payroll deduction forms and give them to the Payroll Administrator; and

› Review the list bill with the Payroll Administrator once received from the Group/Association Case Coordinator.

Once the list bill is approved, the Group/Association Case Coordinator will assign you to a premium accounting representative for any further billing needs.

Portability

The insured may keep the coverage on an individual basis in the event he/she leaves the employer or the membership of an association. No conversion is necessary.

Payroll deduction and association eligibility requirements

A minimum of five lives are required for the list bill payment method with full underwriting. Applications that do not meet the minimum requirement may be marketed for bank draft or direct bill premium payment options.

Employee and member eligibility requirements

Individuals who currently qualify for disability benefits or have been diagnosed as HIV positive or with AIDS or ARC (AIDS-related complex) are not eligible.

Eligible associations

To be considered eligible for this program an association must operate with a charter and/or by-laws and provide support programs or benefits of significance to members. In addition, the association cannot be formed solely to obtain insurance coverage. Professional, trade and employer associations are examples of associations that would qualify.

Associations must agree to cooperate with the agent and promote awareness/participation among its members.

Payroll deduction premium and billing information

Two options are offered for employers:

› List bill – with at least five issued policies.

› Bank draft – The Payroll Administrator may choose to remit the premiums for their employees by means of a common employer account utilizing bank draft, only when employee premiums are payroll deducted.

Association premium and billing information

Two options are offered for Association business:

› Bank draft – Applicants may choose to pay their premiums through a personal bank account on an individual EFT basis.

› Direct bill – Applicants may choose to pay their premiums on an individual quarterly, semiannually, or annually direct bill basis.

Approval process

Each Employer/Association must be approved prior to any business being written. Please complete the Payroll Deduction Setup Form and fax it to New Business: Attn. Group/Association Case Coordinator at 512.467.7403 or email to CSBNewBusiness@Cigna.com.

The approval process normally requires five business days. Upon approval, the Group/Association Case Coordinator will contact you to provide you with your association number. This number must be included in the designated area of each application on all future business submitted.

Issue dates

For list bill business, listing an issue date on the application is mandatory and should be based on the employer having deducted at least one month's premium.

For example: If an employer started deducting September 1, the issue date would be October 1.

For bank draft or direct bill an issue date may be requested, but is not mandatory.

Submission of new business

Hold the applications until you have reached the minimum of five lives, if requesting list bill. Applications submitted under Payroll Deduction/Association guidelines can be submitted up to 60 days from the date of the application, or the date selected by Loyal American for a list bill.

Premium with application

Bank draft – May submit first month's premium with application, but is not required.

Direct bill – First premium payment is required with the application.

List bill – May submit first premium payment, but is not required.

Regular mail: (Must be accompanied by a check or completed bank draft form for the first modal premium.)

New Business/Imaging
PO Box 559015
Austin, TX 78755-9015

Overnight and Express Mail
Cigna Supplemental Benefits
11200 Lakeline Blvd., Suite 100
Austin, TX 78717

GROUP/ASSOCIATION **SETUP FORM**

Please complete this form and fax to: 512.467.7403 Attn: Group/Association Case Coordinator

- Each Employer/Association must be approved before any business may be written or submitted.
- List bill only: Employer must submit applications on at least five lives and must maintain a minimum of five lives to be eligible for list bill.
- Please type or carefully print all of the following information.

EMPLOYER/ASSOCIATION INFORMATION

Employer/Association name: Tax ID: #

Street address: Phone number: ( )

City: State: Zip: Fax number: ( )

Nature of business: Email address:

List bill only: Part of Section 125 Plan? ☐ Yes ☐ No If Yes, identify Plan Administrator:

List bill only: Will all employees participate in Section 125? ☐ Yes ☐ No Plan mode:

PRODUCTS TO BE WRITTEN

☐ American Retirement Life Insurance Company ☐ Loyal American Life Insurance Company *(Referred to as "Company")*

Products to be written: _____

Are any existing products intended to be replaced? ☐ Yes ☐ No If "Yes," which ones:

BILLING CONTACT INFORMATION (list bill only)

Should Billing Information be verified with the Agent prior to contacting the employer? ☐ Yes ☐ No

Billing contact person and title: Ext.:

Billing address *(if different from above):* City: State: Zip:

Is this a third-party administrator? ☐ Yes ☐ No If "Yes," has the TPA been approved by the Home Office? ☐ Yes ☐ No If "No," contact the Company.

Is this a common remitter? ☐ Yes ☐ No If "Yes," we require a letter/agreement showing that the party collecting the premium is an agent acting on behalf of the employer/association.

Is this a multilocation employer? ☐ Yes ☐ No If "Yes," how many and what states:

Will all of the bills be coordinated through one office? ☐ Yes ☐ No

Will this be an electronic enrollment? ☐ Yes ☐ No If "Yes," whose system: **Home Office Approval Code:**_____

BILLING SET-UP INFORMATION

Billing method *Please select one:* ☐ Monthly bank draft ☐ List bill
Note: To calculate list bill premium, multiply the annual/monthly bank draft premium by the appropriate factor. (see Agent Guide)

Bank draft only: *Drafts will occur from:* ☐ Each individual member's account ☐ One employer account

List bill only: Premium billing order *(Please select one):* ☐ Alpha ☐ Social Security # ☐ Policy #
Billing frequency *(How often bill is sent):* ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual
☐ Other *Refer to the product application for available "other" billing frequencies.*
First payroll deduction date: / / ☐ None: Benefits are employer paid

Requested issue date: / / ***(The issue date is the day the first payment is due.)***

Note: Policy issue dates should be based on at least five weekly or three biweekly deductions having been made. Please refer to the product application for available 'other' billing frequencies.

Billings are mailed 10 days prior to the premium due date. Alternate date requested:

GROUP/ASSOCIATION **SETUP FORM**

AGENT INFORMATION

Servicing Agent name:	Phone number: ( )
Email address:	Fax number: ( )

If you are requesting Payroll Deduction/List Bill, this section must be completed.

Employer agrees to PAYROLL DEDUCTION program: ☐ Yes ☐ No

Employer agrees to make payroll deduction of premiums, as authorized by employees, and forward the aggregate sum thereof to the Company, upon the receipt of the list bill. The Employer bears no liability, responsibility or obligation for the employee's insurance or for the late payment or premium except as provided herein. Employer agrees from the date of payroll deduction, the sums withheld are the property of the Company, and the Employer holds such amounts as an agent of the Company with the sole obligation of remittance.

If Employer mandates a minimum participation level before payroll deduction will be authorized, state participation level here:

_____

The Company agrees to furnish a statement indicating the premium due by each participating employee. Employer agrees to make remittance within 10 days of its receipt of the monthly statement. Employer also agrees to promptly notify the Company of the name, address and phone number of any participating employee who leaves its employment, or withdraws a salary deduction authorization of from whom payment will not be made. If Employer terminates this agreement by 30 days written notice to the Company, Employer will be fully discharged upon remittance of premiums theretofore deducted. In the event premiums are no longer to be withheld by payroll deduction, the premiums are to be paid directly by the Employee to the Company.

If an Employee's premium is altered from the date of application, the Company will communicate this with the agent at the time of policy issue. It is the agent's responsibility to communicate these changes in premium to the Employer and coordinate the update in premium deduction for the Employee.

AGENT AND EMPLOYER ACKNOWLEDGEMENT:

I understand that only the Company's President, Vice President or Secretary has the power to modify or amend any policy, coverage, premium, underwriting or any other procedure or benefit. No agent may accept risks, alter or amend policies or procedures, or waive any provisions of the Payroll Deduction Program or policy. To the best of my knowledge, the information on this form is correct.

Name and title of representative: _____

Signature: _____ Date: _____

Servicing Agent name: _____

Signature: _____ Date: _____

Additional Comments

_____

_____

_____

PAYROLL DEDUCTION **FORM**

Please complete this form and **fax with the completed new business applications to 877.704.8186.**

Employee Authorization for Deduction of Premiums from Salary: I hereby request that you deduct from my salary and forward to the Company the appropriate premium. Such deductions will cease upon (1) termination of my employment, (2) written notice by me requesting that deductions cease and stating when such cancellation is to be effective, (3) termination of this payroll deduction plan, or (4) written notice from the Company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization of my part, verbal or written, provided that the insurance company above certifies in writing that the changes in premium uniformly affect all members of the class to which I belong.

INFORMATION

Date:	Employee SSN #:		
Employee's name *(print)*:			
Spouse's name *(if applicable)*:			
Approximate monthly premium:	Employee $	Spouse $	Total $
Requested effective date:			

Employee's signature: _____

APPENDIX A

Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Supplemental Benefits (CSB)

Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Supplemental Benefits (CSB)

As an insurance producer, your skills and services help your customers achieve financial success and security. Because you are on the front lines of a multi-billion dollar industry, you are in a unique position not only to serve your customers, but also to serve the country by helping prevent money laundering and the financing of terrorist activities.

To comply with the federal anti-money laundering regulations for insurance companies, CSB has adopted a detailed anti-money laundering program. You have an important role to play in that program. As a person who deals directly with customers, you will often be in a critical position to obtain information regarding the customer, the customer's source of funds for the products you sell, and the customer's reasons for purchasing an insurance product. You should expect to collect and retain information needed to assess the risk associated with a particular piece of business – in particular, to identify customers in high-risk businesses or high-risk geographic locations, or those using products or services that may be more susceptible to abuse in money laundering or other illegal activity.

Required training

Federal regulations (31 CFR 103.137) require CSB insurance companies to provide their agents and producers with ongoing anti-money laundering training. Thus in order to avoid delays in new business processing, CSB requires that you successfully complete anti-money laundering training provided by LIMRA on an annual basis.

If you are appointed with another insurance company(s) that also utilizes LIMRA for its AML training, you need only take the training once. LIMRA will automatically share the results with all other insurance companies you are appointed with that use LIMRA for its training.

To access LIMRA Anti-Money Laundering training visit https://aml.limra.com and enter your username and password in lowercase letters in the spaces provided. (The login function is case sensitive.) Your username is the first four letters of your last name plus the last six digits of your Social Security number. If this is the first time accessing the course, your password is your last name. For example, John Smith, whose Social Security number is 000-12-3456 would have the following username and password:

› Username: smit123456

› Password: smith

You will then be prompted to change your password.

Click on the Login button.

Complete one of the appropriate Anti-Money Laundering courses. CSB will automatically receive notification of your course completion.

If you have any AML training program questions, please contact CSB Agent Contracting at 877.454.0923.

Customer information gathering

In order to sell individual whole life insurance policies and other insurance products offered by a CSB insurance company that have a cash value or an investment feature, CSB's anti-money laundering program requires you to ensure that all information requested on the product application form and on any associated documents is accurate and complete. If a customer resists providing any requested information, appears to have provided false or misleading information, refuses to provide an acceptable form of identification or has otherwise provided information that cannot be verified, before contracting you should promptly contact Bridgette Bosier, of the CSB Compliance Department at 512.531.1421, and follow any instructions you are given. Records of this information must be retained as long as the policy or contract remains in force and for five years thereafter.

Customer information gathering cont'd

CSB insurance companies have developed a Notice and Customer Information Form (AR-NCIF or LY-NCIF) to help ensure that all required customer information is obtained. At this time this form must be used in all individual whole life product sales and in connection with the sale of any other individual insurance product that has a cash value or investment feature. An exception may be available as determined by the CSB Compliance Department for a final expense product, but only if a personal history interview and prescription verification are utilized by the CSB insurance company during the underwriting process.

Suspicious activity reporting

You must immediately notify us if you detect any money laundering red flags, so that CSB can determine whether a suspicious activity report (SAR) must be filed with the U.S. Department of the Treasury. Typically a SAR must be filed within thirty (30) days of the initial detection of the suspicious activity.

Insurance Industry red flags include, but are not limited to:

- The purchase of a product that appears to be inconsistent with a customer's needs;
- The purchase or funding of a product that appears to exceed a customer's known income or liquid net worth;
- Any attempted unusual method of payment, particularly by currency or cash equivalents such as money orders, traveler's checks or cashier's checks;
- Payment of a large amount broken into small amounts;
- Little or no concern expressed by a customer for the investment performance of an insurance product, but much concern expressed about the early termination features of the product;
- The reluctance of a customer to provide identifying information, or the provision of information that seems fictitious;
- A customer inquiring about how to borrow the maximum amount available soon after purchasing the product;
- Listing a beneficiary or payee who is apparently an unrelated third party or who otherwise has no apparent relationship to the customer;
- A customer applies for a policy out-of-state when the same or similar product is available in his/her home state;
- The customer uses an out of state mailing address; and
- Any other activity that you think is suspicious.

If you identify any suspicious activity or money laundering red flags, you must promptly notify the CSB AML Compliance Contact, Bridgette Bosier, at 512.531.1421. In that regard, you may be asked by the CSB AML Compliance Contact or by other CSB management personnel to investigate further or obtain additional information from the customer. If so requested, you must expeditiously obtain any requested information so CSB can determine in a timely manner if a SAR needs to be filed.

The CSB AML Compliance Officer/Contact has the sole responsibility for determining whether to file a SAR and for responding to any regulatory agency's, customer's, employee's, agent's or producer's inquiry regarding suspicious activity or SAR. The fact that a suspicious activity is under investigation, or that a SAR has been filed or considered – including the contents of any SAR that has been filed – are strictly confidential. An agent or producer must not, under any circumstances, disclose that a suspicious activity is under investigation or that a SAR has been filed or is being considered – including the contents of a SAR – to the subject of a the suspicious activity investigation or SAR, or to any third party. Violations of confidentiality related to suspicious activity investigations or reporting may result in substantial civil and/or criminal penalties.

Methods of payment

You should advise the customer that only the following types of payment may be used to purchase an insurance product from a CSB insurance company:

- Properly completed pre-authorized checking account drafting form;
- Personal check made payable to the appropriate CSB insurance company;
- Properly completed payroll deduction authorization form;
- Wire Transfers and other forms of electronic funds transfer; or
- Checks from another financial institution made payable to a CSB insurance company for the benefit of a new or existing customer.

If a customer gives you an unacceptable form of payment, you should explain what forms of payment are acceptable, return the unacceptable payment immediately and notify the CSB AML Compliance Contact of the red flag. You should also notify the CSB AML Compliance Contact if you encounter difficulty dealing with a customer regarding CSB's standards for acceptable and unacceptable forms of payment. The CSB Compliance Contact can be reached at 512.531.1421.

Both CSB insurance companies and their producers share the responsibility of compliance with CSB's AML Program and all applicable anti-money laundering laws. A failure to do so will constitute grounds for discipline up to and including termination of your contract for cause. In addition, violation of anti-money laundering laws may expose those responsible to substantial civil and criminal penalties under federal law.

Contact list

We value you as an agent with Cigna Supplemental Benefits. Your business is very important to us and we strive to make doing business with us as easy as possible. Your recruiter/upline should be your first point of contact. You can also contact the numbers and or email addresses listed below for ongoing matters.

Agent Resource Line	877.454.0923	
Phone Verification (PV) Hotline	866.825.4822	CSBNewBusiness@Cigna.com
All Claims	866.459.1755	

To reach any of the following departments, call: 877.454.0923;		
New Business		CSBNewBusiness@Cigna.com
Underwriting		CSBNewBusiness@Cigna.com
Commissions		CSBCommissions@Cigna.com
Licensing and Website Registration		CSBLicensing@Cigna.com
Website Login Assistance		CSBAccountService@Cigna.com
Product Availability		CSBAgentMarketing@Cigna.com
Customer Services		CSBSupport@Cigna.com

Fax numbers

New Business Requirements	888.695.2591	
FaxApp Submission	877.704.8186	
Customer Services	888.670.0146	
Premium Accounting	888.670.0146	
Claims	512.531.1480	
Supplies	888.417.8267	CSBSupplies@Cigna.com
Commissions	512.531.1469	
Licensing	888.832.4154	

Addresses

New Business/Imaging
PO Box 559015
Austin, TX 78755-9015

Overnight and Express Mail
Cigna Supplemental Benefits
11200 Lakeline Blvd., Suite 100
Austin, TX 78717

Customer Services
PO Box 26580
Austin, TX 78755-0580

Products insured by American Retirement Life Insurance Company or Loyal American Life Insurance Company

ARLIC-1-0008 2/15