

Group Hospital Confinement Indemnity Insurance



If you got sick or hurt, could you cover all of your medical expenses?

Even if you have coverage that helps with most of the expenses, you may still have to deal with deductibles, co-payments and co-insurance.

Not to mention all the other bills you're already paying each month—mortgage, groceries, electricity and gasoline. That money has to come from somewhere, too.

Colonial Life's Hospital Confinement Indemnity Insurance plan offers added financial protection for those out-of-pocket costs related to a covered accident or a covered sickness.

A \$1,000.00 **Hospital Confinement Benefit** can help pay for the costs associated with a hospital stay.

Maximum of 1 benefit per calendar year per covered person.

An **Outpatient Surgical Procedure Benefit** can help cover the costs associated with a covered surgical procedure.

Maximum of \$ 1,500.00 per covered person per calendar year for Tiers 1 and 2 combined.

Tier 1 Outpatient Surgical Procedure Benefit \$ 500.00

Breast

Axillary node dissection
Breast capsulotomy
Breast reconstruction
Lumpectomy

Cardiac

Pacemaker insertion

Digestive

Colonoscopy
Fistulotomy
Hemorrhoidectomy (external)
Lysis of adhesions

Skin

Laparoscopic hernia repair
Skin grafting

Ear/Nose/Throat/Mouth

Adenoidectomy
Removal of oral lesions
Myringotomy
Tonsillectomy
Tracheostomy

Gynecological

Dilation & Curettage (D&C)
Endometrial ablation
Lysis of adhesions

Liver

Paracentesis

Musculoskeletal System

Carpal/cubital repair or release
Dislocation (closed reduction treatment) other than a finger or toe
Foot surgery (bunionectomy, exostectomy, arthroplasty, hammertoe repair)
Fracture (closed reduction treatment) other than a rib, finger or toe
Removal of orthopedic hardware
Removal of tendon lesion

Tier 2 Outpatient Surgical Procedure Benefit \$ 1,000.00

<p>Breast Breast reduction</p> <p>Cardiac Angioplasty Cardiac catheterization</p> <p>Digestive Exploratory laparoscopy Laparoscopic appendectomy Laparoscopic cholecystectomy</p> <p>Ear/Nose/Throat/Mouth Ethmoidectomy Mastoidectomy</p>	<p>Ear/Nose/Throat/Mouth, cont. Septoplasty Stapedectomy Tympanoplasty Tympanotomy</p> <p>Eye Cataract surgery Corneal surgery (penetrating keratoplasty) Glaucoma surgery (trabeculectomy) Vitrectomy</p> <p>Gynecological Myomectomy</p>	<p>Musculoskeletal System Arthroscopic knee surgery w/ meniscectomy (knee cartilage repair) Arthroscopic shoulder surgery Clavicle resection Dislocations (ORIF - open reduction with internal fixation) Fracture (ORIF - open reduction with internal fixation) Removal or implantation of cartilage Tendon/ligament repair</p> <p>Thyroid Excision of a mass</p>
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The surgeries listed above are only a sampling of the surgeries that may be covered. Surgeries must be performed by a doctor in a hospital or ambulatory surgical center. For complete details and definitions, please refer to your certificate.

Plus, with all Colonial Life insurance coverage...

- Benefits are paid directly to you, unless you specify otherwise.
- Your benefits are paid regardless of any other coverage you may have.

Think about it.

One plan could offer you even more financial protection. That's Colonial Life, *making benefits count*.

Issue Age	Rates Per Month			
	Named Insured Only	Employee +Spouse	Employee Child(ren)	Family
17-49	\$20.36	\$36.49	\$29.96	\$46.09
50-59	\$22.59	\$43.70	\$30.77	\$51.88
60-64	\$29.70	\$59.92	\$37.88	\$68.10
65-99	\$38.63	\$79.08	\$46.81	\$87.23

We will not provide benefits for injuries received in accidents or sicknesses which are caused by: alcoholism, drug addiction, dental procedures, elective procedures, cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, serving in the armed forces, serving in the armed forces or giving birth within the first 9 months after the certificate effective date. We will not pay benefits for loss due to a pre-existing condition as defined in the certificate unless the pre-existing limitation period stated in the certificate schedule has been satisfied.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-AR. This is not an insurance contract and only the actual certificate provisions will control.

Colonial Life
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Columbia, South Carolina 29210
coloniallife.com

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Colonial Life & Accident Insurance Company
P.O. Box 1365, Columbia, SC 29202-1365

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE ENROLLMENT FORM

Named Insured Section				
Named Insured (First, MI, Last)		Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street		City	State	Zip Code
Employee ID/Payroll No.			Email Address	
Home Phone No.			Business Phone No.	
Date Employed	Occupation/Job Title	Annual Income	Hrs. Worked/Week	Employee Class

Billing Section		
Employer Name Johnson Employer Support Services	Employer Address (Street-City-State-Zip) 201 W. 5th St. El Dorado AR 71730	Section/Dept. No.

Spouse Section					
Is your spouse applying for coverage? If yes, provide identifying information below.				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name of Spouse (First, MI, Last)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.	

Plan Section			
Type of Coverage	Base Plan Code(s)	P = Pre-Tax A = After-Tax	Monthly Premium
<input type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured & Spouse <input type="checkbox"/> Named Insured & Dependents <input type="checkbox"/> Named Insured, Spouse & Dependents		P <input type="checkbox"/> A <input type="checkbox"/>	\$

Agreement Section
<p>I understand that the coverage applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I now have or have had in the past. By applying for the coverage indicated above, I am requesting cancellation of existing Hospital Confinement Insurance with Colonial Life & Accident Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If, for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby state the statements are true and have been completed to the best of my knowledge and belief.</p> <p>Signed at: City _____ State _____ Date _____ mm/dd/yyyy</p> <p>(x) _____ Signature of Proposed Insured (if applicable)</p>

Agent Section
<p>I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance coverage in detail.</p> <p>Date _____ (x) _____ Signature of Licensed Agent (if applicable)</p> <p>Agent Name _____ License No. _____ Code No. _____</p>