GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF CALIFORNIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations, and exclusions of the Policy except as this Rider specifically modifies them.

1. The following is added to Section VII Claims Provisions:

   (a) If the Policy includes any periodic payment which depends on continuing loss, written proof of loss must be given to Us within 90 days after the end of the period for which the Company is liable.

   (b) Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the extent benefits for the same expenses are paid to the provider.

2. The following is added to the Accident Medical Expense Benefit:

   (a) Benefits for services given by the following licensed or certified provider acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).

   (b) Speech Therapist's Services

   Benefits for services given by a licensed or certified speech therapist acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).
   Services of a speech therapist including restorative or rehabilitative speech therapy.
   These services must be in connection with speech loss, impairment, or defect due to a covered Occupational Injury.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in- force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 **et seq**.), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;

- $300,000 for disability insurance benefits;

- $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;

- $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life ($500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);

- Their insurer was not authorized to do business in the District of Columbia; or

- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;

- Any policy of reinsurance (unless an assumption certificate was issued);

- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;

- Interest rate guarantees which exceed certain statutory limitations;

- Dividends, experience rating credits or fees for services in connection with a policy;

- Credits given in connection with the administration of a policy by a group contract holder; or

- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

NOTICE NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, NJ 07102

State of New Jersey Department of Banking and Insurance
20 West State Street
P.O. Box-325
Trenton, NJ 08625-0325

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17 B: 32 A-1, et seq. (the "Act").

COVERAGE

Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self- funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for annuity benefits, $500,000 in life insurance death benefits or $500,000 in present value of annuities - - again no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

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RIDER APPLICABLE TO RESIDENTS OF NEW JERSEY

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

The following is added to Section VII Claims Provisions:

1. All payments will be made within 60 days of the date the Company receives satisfactory proof of loss.

2. If a claim or a portion of a claim is contested by the Company, the claimant will be notified in writing within 45 days of the date of receipt of the claim. Any uncontested portion of the claim will be paid within 60 days of the date of receipt of the claim. The Insured Person will receive a written explanation of any claim denial.

3. Upon receipt of the requested additional information, the Company will pay or deny the contested claim or portion of the contested claim within 90 days.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, his Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

GREAT AMERICAN INSURANCE GROUP
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NORTH CAROLINA POLICYHOLDER NOTICE

We have issued the Group Policy referenced on the Schedule of Benefits (called the policy) to the Motor Carrier or Policyholder.

IMPORTANT NOTICES

THIS POLICY IS EVIDENCE OF A CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY. PLEASE READ THIS POLICY CAREFULLY

THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.

THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. THIS

POLICY IS GOVERNED BY THE LAWS OF THE STATE IN WHICH IT IS DELIVERED.

Non-Participating Insurance

NORTH CAROLINA FIDUCIARY NOTICE: UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMO's) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted **in the box** below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. **On the back of this page** is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;

- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus.

- Any policy of reinsurance (unless an assumption certificate was issued);

- Interest rate yields that exceed the average rate specified in the law;

- Dividends;

- Experience or other credits given in connection with the administration of a policy by a group contractholder;

- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to insurance health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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RIDER APPLICABLE TO RESIDENTS OF NORTH CAROLINA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's or certificate's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

Section I, GENERAL DEFINITIONS, is amended as follows:

The definition of **Occupational** is hereby deleted and replaced with the following:

> **Occupational** means, with respect to an activity, Accident, incident, circumstance or condition involving an Insured, that the activity, Accident, incident, circumstance or condition is proximately caused by the Insured's performing services within the course and scope of contractual obligations for the Contractee. With respect to an Authorized Passenger, the term Occupational means that the activity, Accident, incident, circumstance or condition occurs during and is proximately caused: (a) while the Insured is performing Occupational services; and (b) by and during the Authorized Passenger's riding as a passenger in or on (including getting in or out of, or on or off of) the vehicle. "Occupational" does not encompass any period of time during the course of travel between an Insured's residence and any place at which the Insured performs Occupational services, except as specifically provided under the Policy.

The definition of **Pre-Existing Conditions** is hereby deleted and replaced with the following:

> **Pre-Existing Condition** means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the Insured Person's effective date of coverage under this Policy.

The definition of **Spouse** is hereby deleted and replaced with the following:

> **Spouse** means the person to whom the Insured Person is legally married and with whom the Insured Person co-habits in a continuous and open manner. The term Spouse shall conform to meet the legal requirements of the state that governs the interpretation of this Policy. An Insured Person may have only one legal spouse regardless of any potential change in how such stated defines the term.

Section II, EFFECTIVE PERIOD, is amended as follows:

- The **Policy Termination Date** provision is hereby deleted and replaced with the following:

> **Policy Termination Date.** The effective period of this Policy will end at 12:01 A.M. Standard Time at the Policyholder's address on the earliest of:
>
> (1) The Policy Anniversary/Termination Date shown on the Schedule of Benefits page, unless renewed before that date;
> (2) The premium due date, if we do not receive a required premium payment on or before that date, subject to the Grace Period provision;
> (3) The date specified in any written notice of the Company's intent to terminate this Policy, which will be at least forty-five (45) days after the date the Company sends such notice to the Policyholder's and Certificate holder's last known mailing address; or
> (4) The date specified in any written notice of the Insured's intent to terminate this Policy, which must be at least thirty-one (31) days after the date the Policyholder send such notice to the Company.

Termination of this Policy before its anniversary date will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

- The **Policy Non-Renewal** provision is hereby deleted and replaced with the following:

  Policy Non-Renewal. If the Company determines to not offer renewal terms for this Policy, a notice to the Policyholder will be mailed no less than 45 days prior to the termination date listed on the Schedule of Benefits.

Section III, PREMIUM, is amended as follows:

- The **Premiums** provision is hereby deleted and replaced with the following:

  Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premium section of the Schedule of Benefits. The Company may change the required premiums due by giving the Policyholder at least forty-five (45) days advance written notice. Premium changes may be provided based on the Policy's experience at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience. Any change in premiums after the first year shall not be made any more frequently than once every six months. The Company may also change the required premiums at any time when any change affecting premiums is made in this Policy.

- A **Grace Period** provision is hereby deleted and replaced with the following:

  Grace Period. If your premium is paid monthly, a grace period of 7 days will be provided for the payment of any premium due after the first premium. If your premium is pre-paid for the entire term of your certificate, a grace period of 31 days will be provided for the payment of any premium due after the first premium. The policy will continue in force during the grace period, subject to the Policy's termination and non-renewal provisions.

Section IV, BENEFITS, is amended as follows:

- The following paragraph is added after the third paragraph under the Temporary Total Disability Benefit provision:

  Unless the Temporary Total Disability Benefit ceases because the Insured Person is no longer Temporary Totally Disabled or because the Insured Person dies, the Temporary Total Disability Benefit will be paid for a minimum of 90 days for each Single Period of Total Disability up to the Maximum Benefit Period shown in the Schedule of Benefits.

- The second paragraph under the Continuous Total Disability Benefit was deleted and replaced with the following:

  The Continuous Total Disability Benefit with respect to each month of an Insured Person's Continuous Total Disability is equal to four and three-tenths (4.3) times the weekly benefit for Temporary Total Disability, less the Insured Person's primary Social Security Disability Award in effect on the date the Continuous Total Disability benefits became payable.

- The definition of **Hospital** within the Accident Medical Expense Benefit is deleted and replaced with the following:

  Hospital means a facility, including a duly licensed state tax-supported institution, that:

  (1) is operated according to law for the care and treatment of injured people;
  (2) has organized facilities for diagnosis and surgery on its premises, or in facilities available to it on a prearranged basis;
  (3) has 24-hour nursing service by registered nurses (R.N.'s) on duty or on call; and
  (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other selection of the hospital that is used for such purposes; or (3) any military or veterans' hospital or soldiers' or sailors' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

  "State tax-supported institution" includes community mental health centers and other health clinics which are

certified as Medicaid providers.

Section VI, EXCLUSIONS, is amended as follows:

- Exclusion 3 regarding Pre-Existing Conditions is hereby deleted and replaced with the following:

  3. any Pre-Existing Condition, unless the Insured Person has been continuously covered under this Policy (or a substantially identical policy issued by the Company or another insurer, of which this policy is a renewal) for one year; (If the Insured Person has reached their 65th birthday at the time of a Covered Loss, and resides in North Carolina, this exclusion is not applicable.)

- Exclusion 11 regarding benefits payable under workers compensation or any other similar legislation is hereby deleted and replaced with the following:

  11. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

- Exclusion 13 regarding drugs and intoxicants is hereby deleted and replaced with the following:

  13. The Insured Person's being intoxicated or under the influence of a narcotic, unless taken at the direction of his or her Physician, except with regard to Accidental Medical Expense Benefits under this Policy; or

Section VII, CLAIMS PROVISIONS, is amended as follows:

- The **Notice of Claim** provision is hereby deleted and replaced with the following:

  Notice of Claim. Written notice of claim must be received by the Company within 20 days after an Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Notice must be given by or on behalf of the claimant to the Company at Great American Insurance Company, On Demand Claims, 301 East Fourth Street, 22nd Floor, Cincinnati, OH 45202, 1-833-444-0161, or to an authorized agent of the Company, with information sufficient to identify the Insured Person.

- The **Proof of Loss** provision is hereby deleted and replaced with the following:

  Proof of Loss. Written proof of loss must be furnished to the Company within 180 days after the date of the Covered Loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility and of the loss must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured Person, later than one year from the time proof is otherwise required.

- The **Payment of Claims** provision is amended to include the following sentence at the end of the first paragraph in the provision.

  If there is no designated beneficiary or no designated beneficiary is living, any remaining amount still payable under this Policy will be made to the Insured Person's estate,

- The **Time of Payment of Claims** provision is deleted and replaced with the following:

  Time of Payment of Claims. Benefits payable under the Policy, other than for loss which the Policy provides for periodic payments, will be paid immediately after the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon

receipt of such proof.

Section VIII, GENERAL PROVISIONS, is amended as follows:

- The **Beneficiary Designation and Change** provision is deleted and replaced with the following:

  Beneficiary Designation and Change. The Insured Person's designated beneficiary(ies) is (are) the person(s) so named by the Insured Person and on signed record with the Policyholder and the Insurance Agency listed on the Schedule of Benefits. Designated Benefiticary(ies) means the person(s) so named by the Insured Person and on properly executed forms filed with the Policyholder and the Insurance Agency listed on the Schedule of Benefits page. Designated Beneficiaries are restricted to the Insured Person's Spouse and/or Dependent Child(ren). If the Insured Person is not survived by a Spouse or Dependent Child(ren), another living person may be designated in writing as his or her beneficiary. If there is no designated beneficiary or no designated beneficiary is living, any remaining amount still payable under this Policy will be made to the Insured Person's estate. Note that any beneficiary not meeting the definition of Spouse or Dependent Child(ren) will qualify only for the Lump Sum Benefit payment as described in the Schedule of Benefits and will not qualify Survivor Benefits described in the Schedule of Benefits.

  A legally competent Insured Person over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advanced by the Company, the Policyholder and the Insurance Agency listed on the Schedule of Benefits with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, the Policyholder or Authorized Insurance Agent, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but will not apply to or prejudice the Company as respects any payment which may have been made prior to the Company's receipt of the request.

- The **Subrogation** provision is deleted in its entirety.

- The **Right to Recover Overpayments** is deleted and replaced with the following:

  Right to Recover Overpayments. In addition to any rights of recovery or reimbursement provided to the Company herein or which the Company may have by operation of law, when payments have been made by the Company with respect to a Covered Loss in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this Policy, the Company shall have the right to recover such excess payment from any one or more of the following: any person to whom such payments were made (e.g., medical providers, etc.), the Insured Person, any beneficiary, any insurance company, or any other organization(s) which received, or should have received, the payment.

- The first paragraph of the **Conditional Claim Payment** provision is hereby deleted and replaced with the following:

  Conditional Claim Payment. If an Insured Person suffers Covered Loss(es) as the result of Injuries for which, in the opinion of the Company, a third party may be liable, the Company will pay the amount of benefits otherwise payable under this Policy.
  However, if the Insured Person receives, collects, or recovers damages or other payment from the third party, the Insured Person agrees to refund to the Company the lesser of: (1) the amount actually paid by the Company for such Covered Loss(es); or (2) an amount equal to the sum actually received from the third party for such Covered Loss(es).

- The definition of **Plan** under the Allowable Expense provision is hereby deleted and replaced with the following:

  As used above in this section, **plan** includes any of the following coverages which provide benefits or services for, or because of, health care: (1) True group insurance which includes prepayment, group practice or individual practice coverage; and (2) coverage under any governmental plan (including provincial plans) or coverage required or provided by law. **Plan** does not include: (a) school accident-type coverage, blanket, franchise insurance automobile and homeowners coverage; or (b) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (c) this Policy, or (d) a plan or law that, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan.

- The **EXCLUSIONS** sections within Rehabilitation Benefit Rider, Home Health Care Expense Benefit Rider, and Trauma Counseling Benefit Rider are hereby revised to include “under this Policy” after the reference to “Accidental Medical Expense Benefit”.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

Summary Concerning Coverage, Limitations, and Exclusions under the Alaska Life and Health Insurance Guaranty Association Act

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 - 21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

EXCLUSIONS FROM COVERAGE

The association does not protect a person holding a policy if

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;

- a credit given in connection with the administration of a policy by a group contract holder;

- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);

- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;

- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;

- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;

- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;

- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants;

- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even i f such contracts provided different types of coverages, the association will pay a maximum of

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

- for health insurance benefits, $100,000 for coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values;

- $300,000 f o r disability insurance;

- $500,000 f o r basic hospital, medical, and surgical or major medical insurance;

- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- with respect to a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

- $250,000, in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 2 6 U.S.C. 401, 2 6 U.S.C. 403(b), or 2 6 U.S.C. 4 5 7 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;

- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to any one contract holder or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 4 5 7 of the Internal Revenue Code, the limit is $100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guarantee association should not be contacted regarding the financial information of an insurance company.

The association is not an agency of the State of Alaska nor are there any guarantees by the State of Alaska regarding the payment of claims by the association.

Alaska Life and Health Insurance Guaranty Association 1007
West Third Avenue
Anchorage, Alaska 99501
(907) 243-2311

Division of Insurance
550 West Seventh Avenue, Suite 1560
Anchorage, Alaska, 99501-3567
(907) 269-7900

THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION APPENDIX "A" LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association c/o
The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;

- Any policy of reinsurance (unless an assumption certificate was issued);

- Interest rate yields that exceed an average rate;

- Dividends and voting rights and experience rating credits;

- Credits given in connection with the administration of a policy by a group contract holder;

- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);

- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);

- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;

- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life and annuity benefits and $300,000 in health insurance benefits - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within these overall limits, the Association will not pay more than $300,000 in disability and long term care benefits, $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

APPENDIX "B"
NOTICE OF
THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 in life and annuity benefits and $300,000 in health insurance benefits no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit for life and annuity benefits, the Association will pay a maximum of $300,000 in net cash surrender values. $300,000 in life insurance death benefits, and $300,000 in present value of annuities. The Association will pay up to $300,000 for health insurance which does not include disability and long term care insurance which will continue to be subject to the $300,000 limit for health insurance. This new limit will be effective as of August 25, 2013. There is a $300,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:

   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued:

   b. Your insurer was not licensed in this state: or,

   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use existence of the Guaranty Association to induce you to purchase a product from them.

For more information relative to the Act you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

ARKANSAS NOTICE

under a Group Policy issued by Great American Insurance Company, Cincinnati, Ohio 45202-4201

I

NOTICE CONCERNING INSURANCE COMPLAINTS

Should any complaints arise regarding this insurance the Insured may contact the insurer or the Arkansas Department of Insurance at the following addresses:

Complaints other than claims:

Great American Insurance Company, On Demand
301 East 4th Street
Cincinnati, OH 45202-4201
(513) 369-5000

Complaints regarding claims:

Great American Insurance Company, On Demand Claims
301 East 4th Street
Cincinnati, OH 45202-4201
1-833-444-0161

The Arkansas Department of Insurance:

Arkansas Department of Insurance
Consumer Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494

Please include the policy number in any communication with the above addresses.

II

In accordance with Arkansas Code Ann. 23-86-108(4) and the Arkansas Insurance Department Bulletin 14-81, **SECTION I, GENERAL DEFINITIONS, DEPENDENT CHILD(REN)** is amended as follows:

"Dependent Child(ren) means the Insured Person's unmarried children, including natural children from the moment of birth, step or foster children, or adopted children, from the moment of placement in the home of the Insured Person, under age 19 (24 if attending an accredited institution of higher learning on a full-time basis) and primarily dependent on the Insured Person for support and maintenance. It also includes any unmarried Dependent Child(ren) of the Insured Person who are incapable of self- sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured Person for support and maintenance.

At the request and expense of the Company, proof of the incapacity or dependency must be furnished to the Company by the insured or their legal representative, except in no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age. If the incapacity or dependency is thereafter removed or terminated, the insured or their legal representative shall so notify the Company."

President **Secretary**

Exhibit A
California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. I f this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209
(323) 782-0182
or
Consumer Service Division California
Department of Insurance 300 South Spring
Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

Coverage

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of

insured persons are protected as well, even i f they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self- funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion o f a policy which is not guaranteed by the insurer or f o r which the individual has a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate; rating credits.

Limits on Amounts of Coverage

The Act limits the Association to pay benefits as follows:

Life and Annuity Benefits

* 80% of what the life insurance company would owe under a life policy or annuity contract up to * $100,000 in cash surrender values, * $100,000 in present value of annuities, or * $300,000 in life insurance death benefits.* A maximum of $300,000 for any one insured life no matter how many policies and contracts there were with the same company, even i f the policies provided different types of coverages.

Health Benefits

* A maximum of $527,507 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

Premium Surcharge

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

Exhibit B
Notice of Non-Coverage California Life and Health Insurance Guarantee Association Act

These types of polices are NOT covered by The California Life and Health Insurance Guarantee Association

Exclusions from Coverage

The following are not covered by the California Life and Health Insurance Guarantee Association:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by individuals and which guarantee rights to group contract holders, not individuals;

- Employer and association plans, to the extent they are self- funded or uninsured;

- Synthetic guaranteed interest contracts;

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- Any policy of reinsurance unless an assumption certificate was issued;

- Interest rate yields that exceed an average rate;

- Any portion of a contract that provides dividends or experience rating credits.
  A determination as to whether an insurance contract is covered under the Guarantee Association or whether an annuity contract is allocated or unallocated must initially be made by the insurer based on its knowledge of the specific contract offered.

  Also, you are not protected by this Association if:

- The insurer was not authorized to do business in this state when it issued the policy or contract;

- The policy is issued by a health care service plan (HMO), Blue Cross, Blue Shield; a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

- You are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

If you have questions concerning this Notice, you may contact

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209

(323) 782-0182
or
Consumer Service Division California
Department of Insurance 300 South Spring
Street
Los Angeles, CA 90013

(800) 927-4357 or (213) 897-8921
Questions as to specific policies or annuities should be directed to the insurance company offering the product.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF CALIFORNIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations, and exclusions of the Policy except as this Rider specifically modifies them.

1. The following is added to Section VII Claims Provisions:

   (a) If the Policy includes any periodic payment which depends on continuing loss, written proof of loss must be given to Us within 90 days after the end of the period for which the Company is liable.

   (b) Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the extent benefits for the same expenses are paid to the provider.

2. The following is added to the Accident Medical Expense Benefit:

   (a) Benefits for services given by the following licensed or certified provider acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).

   (b) Speech Therapist's Services

   Benefits for services given by a licensed or certified speech therapist acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.).
   Services of a speech therapist including restorative or rehabilitative speech therapy.
   These services must be in connection with speech loss, impairment, or defect due to a covered Occupational Injury.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- **Health Insurance**

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- **Annuities**

  $250,000 in withdrawal and cash values

In general, the maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	**Colorado Division of Insurance** 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF CONNECTICUT

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Section IV Benefits
   (a) Emergency Ambulance Services
   Benefits are payable for emergency ambulance services (including air ambulance) to take a Insured Person to a Hospital if the Insured Person is confined as an inpatient. Benefits for these services are payable at the same level as covered Hospital inpatient services. Benefits are limited to a maximum amount of $500 for any one emergency ambulance service. If the Insured Person is covered under more than one policy, the hospital policy is primary. Benefits for emergency ambulance services are payable directly to the provider of the services. This payment to the provider is subject to the following conditions:
   (1) The provider must comply with the statutory provision for direct payment.
   (2) The provider has not been paid from any other sources.

   (b) Hospital Benefits
   Benefits for services provided by the Veterans Home and Hospital are payable on the same basis as services provided in a Hospital.

   (c) Hospital Charges Diagnostic Related Groups
   When Hospital charges are assigned on a Diagnostic Related Groups basis (as required by law in the jurisdiction where the Hospital is located), the definition of Usual and Customary Charge with respect to the Hospital charges is amended. The amount assigned for the Occupational Accident requiring hospital confinement will be considered to be the Reasonable Charge for that confinement.

   (d) Speech Therapist's Services
   Benefits for services given by a licensed or certified speech therapist acting within the scope of that license or certification are payable if the following conditions are met:
   (1) The services are covered under the Policy.
   (2) Benefits would have been payable if the same service had been given by a Doctor of Medicine (M.D.). Services of a speech therapist including restorative or rehabilitative speech therapy.
   These services must be in connection with speech loss, impairment, or defect due to a covered Occupational Injury.

2. Section VI Exclusions
   Exclusion (13) is replaced by the following:
   (13) No indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereinafter amended, unless prescribed by a physician for the Insured Person.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
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513 369 5000 ph

STATE FRAUD NOTIFICATIONS

IMPORTANT NOTICE

THIS FORM IS TO BE ATTACHED TO ALL APPLICABLE APPLICATIONS AND ENROLLMENTS FOR THE STATES LISTED BELOW:

FLORIDA STATUTE 817.234(1)(b)
"Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

NEW MEXICO STATUTE 59A-16C-8
"ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
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Cincinnati OH 45202-4201
513 369 5000 ph

FLORIDA AMENDATORY RIDER

This Rider is attached to and made part of the Policy and its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's and certificate's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

Section I, GENERAL DEFINITIONS, is amended as follows:

- The definition of **Pre-Existing Condition** is hereby deleted and replaced with the following:

  Pre-Existing Condition means a health condition for which an Insured Person has sought or received medical advice, diagnosis, care or treatment within the six months immediately preceding his or her effective date of coverage under this Policy.

- The definition of **Spouse** is hereby deleted and replaced with the following:

  Spouse means the person to whom the Insured Person is legally married and with whom the Insured person co-habits in a continuous and open manner. The term Spouse shall conform to meet the legal requirements of the state that governs the interpretation of this Policy. An Insured Person may have only one legal spouse regardless of any potential change in how such state defines the term.

Section II, EFFECTIVE PERIOD, is amended as follows:

- The **Policy Termination Date** provision is hereby deleted and replaced with the following:

  Policy Termination Date. The effective period of this Policy will end at 12:01 A.M. Standard Time at the Policyholder's address on the earliest of:

  (1) the Policy Anniversary/Termination Date shown on the Schedule of Benefits page, unless renewed before that date;

  (2) the premium due date, if the Company does not receive a required premium payment on or before that date, provided that the Company mails notice of cancellation within forty-five (45) days after the premium was due;

  (3) the date specified in any written notice of the Company's intent to terminate this Policy, which will be at least forty-five (45) days after the date the Company sends such notice to the Policyholder's and Certificate holder's last known mailing address as shown by the records of the Company; or

  (4) the date specified in any written notice of the Insured's intent to terminate this Policy. Unearned premiums, if any, will be refunded to the Policyholder.

  Termination of this Policy before its anniversary date will not affect any claim for a Covered Loss occurring prior to the effective date of termination.

- The **Policy Non-Renewal** provision is hereby deleted and replaced with the following:

  Policy Non-Renewal. If the Company determines to not offer renewal terms for this Policy, a notice to the Policyholder will be mailed no less than forty-five (45) days prior to the termination date listed on the Schedule of Benefits.

Section III, PREMIUM, is amended as follows:

o The **Premiums** provision is hereby deleted and replaced with the following:

Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premium section of the Schedule of Benefits. The Company may change the required premiums due on any Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least forty-five (45) days advance written notice. The Company may also change the required premiums at any time when any change affecting premiums is made in this Policy.

Section IV, BENEFITS, is amended as follows:

o The definition of **Covered Accident Medical Service(s)** within the Accident Medical Expense Benefit is hereby deleted and replaced with the following:

Covered Accident Medical Service(s) means any of the following services:

1. Hospital semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including, but not limited to, use of the operating room or emergency room); or use of an Ambulatory Medical Center;
2. services of a Physician, a Registered Nurse, LPNs, BSNs, nurse practitioners, PAs, or other kinds of licensed nursing personnel;
3. ambulance service to or from a Hospital;
4. laboratory tests;
5. radiological procedures;
6. anesthetics and the administration of anesthetics;
7. blood, blood products and artificial blood products, and the transfusion thereof;
8. **Physical Therapy, Occupational Therapy and Chiropractic Care.** Physical therapy, Occupational therapy and chiropractic care up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule;
9. rental of Durable Medical Equipment, up to the actual purchase price of such equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances; or
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription; or
12. **Accidental Dental Services.** Dental services, up to the Accidental Dental Benefit Maximum, if any, shown in the Schedule. The term "dental services" means the following specific Dental Services, required to treat a dental Injury as a result of an Occupational Accident which happens while covered:
    (1) Appliances and splints placed on or attached to sound natural teeth
    (2) Full or partial dentures.
    (3) Fixed bridgework if needed because of accidental injury to sound natural teeth
    (4) Prompt repair to sound natural teeth if needed because of accidental injury to those teeth.
13. Services that would have been covered on an inpatient basis will also be covered when provided in a non-hospital setting when provided as an alternative to inpatient Hospital services.

o The definition of **Hospital** within the Accident Medical Expense Benefit is amended to include the following:

Notwithstanding the foregoing, a facility which lacks major surgical facilities and is primarily of a rehabilitative nature shall be considered a Hospital under this Policy if such rehabilitation is specifically for the treatment of a Covered Loss, provided that such facility is a licensed Hospital that holds any of the following accreditations:

(1) American Osteopathic Association;

(2) Commission on the Accreditation of Rehabilitative Facilities; or

(3) Joint Commission on the Accreditation of Hospitals.

If the Schedule of Benefits indicates that a Home Health Care Expense Benefit or a Rehabilitation Benefit is provided by this Policy, then the definition of **Hospital** within such supplemental coverage rider shall conform to this definition.

- The definition of **Continuous Total Disability and Continuously Totally Disabled** within the Continuous Total Disability Benefit is deleted and replaced with the following:

  Continuous Total Disability and Continuously Totally Disabled refer to disability that:
  (1) prevents an Insured Person from performing the material and substantial duties of his or her regular occupation for at least the first 12 months they are disabled; and
  (2) for the period beyond the first 12 months the Insured Person is disabled, would prevent an Insured Person from performing all occupations for which he or she is otherwise qualified by reason of education, training or experience; and
  (3) requires and results in the Insured Person's receiving Continuous Care.
-

Section VI, EXCLUSIONS, is amended as follows:

- Exclusion 11 regarding benefits payable under workers compensation or any other similar legislation is hereby deleted and replaced with the following:

  11. any Injury for which the Insured Person is paid benefits pursuant to any workers' compensation law or other similar legislation.

Section VII, CLAIMS PROVISIONS, is amended as follows:

- The **Notice of Claim** provision is amended to include the following:

  Notice given by or behalf of the claimant to an authorized agent of the Company shall be considered notice to the Company.
- The **Payment of Claims** provision is deleted and replaced with the following:

  Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section. Upon receipt of due written proof of loss, payments for all other losses will be made to (or on behalf of, if applicable) the Insured Person suffering the loss. If an Insured Person dies before all payments required under this policy have been made, then any remaining amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

  If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $3,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's sole judgment, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

  The Company may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. Such request must be

made no later than the time proof of loss is filed. Any payment the Company makes in good faith fully discharges the Company's- liability to the extent of the payment made.

- The **Time of Payment of Claims** provision is deleted and replaced with the following:

  Time of Payment of Claims. Benefits payable under this Policy, other than for loss for which this Policy provides for periodic payments, will be paid within forty-five (45) days after the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

- The **Commutation of Losses** provision is deleted and replaced with the following:

  Commutation of Losses. At any time later than two years from the date of any Accident resulting in a claim under this Policy, the Company may request a release from liability with respect to any such claim. If the Insured Person is in agreement, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and the payment by the Company of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim

- The **Sunset** provision is deleted and replaced with the following:

  Sunset. No claim by any Insured Person or beneficiary will be considered valid or collectible under this Policy unless full details of such claim have been presented to the Company within two (2) years from the date of the Accident which gives rise to such claim**.** However this provision will not apply if the Insured Person is legally incapacitated.

Section VIII, GENERAL PROVISIONS, is amended as follows:

- The **Beneficiary Designation and Change** provision is deleted and replaced with the following:

  Beneficiary Designation and Change. The Insured Person's designated beneficiary(ies) is (are) the person(s) so named by the Insured Person and on signed record with the Policyholder and the Insurance Agency listed on the Schedule of Benefits. Designated Beneficiary(ies) means the person(s) so named by the Insured Person and on properly executed forms filed with the Policyholder and the Insurance Agency listed on the Schedule of Benefits page. Designated Beneficiaries are restricted to the Insured Person's Spouse and /or Dependent Child(ren). If the Insured person is not survived by a Spouse or Dependent Child(ren), another living person may be designated in writing as his or her beneficiary. If there is no designated beneficiary or no designated beneficiary is living, any remaining amount still payable under this Policy will be made to the Insured Person's estate. Note that any beneficiary not meeting the definition of Spouse or Dependent Child(ren) will qualify only for the Lump Sum Benefit payment as described in the Schedule of Benefits and will not qualify for the Survivor Benefits described in the Schedule of Benefits.

  A legally competent Insured Person over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company or, if agreed upon in advance by the Company, the Policyholder and the Insurance Agency listed on the Schedule of Benefits with a written request for change. When the request is received by the Company or, if agreed upon in advance by the Company, the Policyholder or Authorized Insurance Agent, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect

as of the date of execution of the written request, but will not apply to or prejudice the Company as respects any payment which may have been made prior to the Company's receipt of the request.

- The **Legal Actions** provision is deleted and replaced with the following:

  No legal action for a claim can be brought against the Company until 60 days after receipt of proof of loss. No legal action for a claim can be brought against the Company after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

- The **Conformity With State Statutes** provision is deleted and replaced with the following:

  Conformity With State Statutes: Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

- The **Right to Receive and Release Needed Information** provision is deleted and replaced with the following:

  Right to Receive and Release Needed Information. The Company has the right to decide in its sole judgment what facts it needs to administer this Policy. It may get needed facts from any other organization or person. With the exception of any state or federal reporting requirements, the information secured will not be given to any non-affliated third party. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to determine coverage under this Policy or determine the correct payment of a claim.

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In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF GEORGIA

This rider is attached to and made part of the policy or one of its certificates as of the effective date shown in the schedule of benefits and applies only during the policy's effective period. This rider is subject to all of the provisions, limitations and exclusions of the policy except as this rider specifically modifies them.

1. The following is added to section VII Claims Provisions:

If the Insured Person asks for a claim form from the policyholder or the company and does not Receive it within 10 days, a claim can be filed without it by sending in the bills and describing the situation in a letter. The company may fail to respond to the claim. Within 15 working days of receipt of proof of loss, the company must mail a letter or notice explaining why the claim or any part has not been paid. The letter also has to include a list of any information needed to process the claim.

When the company has received this additional information, they have 15 working days to either pay or deny the claim. The company must explain their decision.

If the company does not meet all of the above conditions, they must pay 18% interest per year. This applies only to benefits due under the policy for which the above procedure has not been followed.

2. The provision captioned Subrogation in section VIII General Provisions is revised to read as follows:

Subrogation. If the Insured Person has a claim for damages or a right to recover damages from a third party or parties for any injury or illness for which benefits are payable under the policy, the company may have a right of recovery. This right of recovery shall be limited to the recovery of any benefits paid for identical covered medical expenses under the policy but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. The company's right of recovery may include compromise settlements. The Insured Person or their attorney must inform us of any legal action or settlement agreement at least ten days prior to settlement or trial. The company will then notify the Insured Person of the amount the company seeks to recover for covered benefits paid. The company's recovery may be reduced by the pro-rata share of the Insured Person's attorney's fees and expenses of litigation.

3. The provision captioned Conditional Claim Payment is eliminated.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF PROTECTION PROVIDED BY IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are: Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender and withdrawal values

Health Insurance

- $500,000 in basic hospital, medical-surgical or major medical insurance benefits
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance Guaranty Association
700 Walnut, Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
Two Ruan Center
601 Locust Street, 4th Floor 50309
Des Moines, IA 50309
(515) 281-5705

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. That information may be accessed from the "Helpful Links & Information" page located on the website of the Iowa Insurance Division at www.iid.state.ia.us.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

GREAT AMERICAN INSURANCE GROUP
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SUMMARY OF THE IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Idaho who purchase life insurance, annuities or health/disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Idaho Life and Health Insurance Guaranty Association. The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for money to pay the claims of insured persons who reside in Idaho and, in some cases, to keep coverage in force. However, the protection provided by these insurers through the Association is limited, and is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

The Idaho Life and Health Insurance Guaranty Association Act provides a safety net for certain purchasers of insurance. Below is a brief summary of the law's coverage, exclusions and limitations. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Association if they live in Idaho and own a life or health/disability insurance policy, an annuity contract, or if they are an insured certificateholder under a group life or health insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of covered policies may be protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies or contracts are not protected by the Association if:

- They are eligible for protection under the laws of another state
- The insurer was not authorized to do business in Idaho
- The policy was issued by a reciprocal insurer, mutual benefit association, fraternal benefit society, hospital and medical service corporation, limited managed care plan, or self-funded health care plan

The Association also does not provide coverage for:

- Any policy or contract or any portion of any policy or contract under which the risk is borne by the policyholder
- Any policy of reinsurance
- Interest rate yields that exceed an average rate
- Unallocated annuity contracts (any annuity not issued to and owned by an individual)

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay out more than what the insurance company would owe under a policy or contract. Furthermore, the amounts the Association is authorized to pay are limited as follows:

- Not more than $100,000 of net cash surrender or net cash withdrawal values under a life insurance, health/disability insurance, or annuity policy or contract.

- Not more than $300,000 of claims or benefit payments under a health/disability policy, other than major medical.

- Not more than $500,000 of claims or benefit payments under a major medical policy.

- Not more than $300,000 of death benefits under a life insurance policy.

- Not more than $250,000 of annuity benefit payments under a contract for which periodic annuity payments have begun to be paid, if the annuitization period chosen was the annuitant's lifetime or a period certain of 10 years or longer; otherwise $100,000 of annuity benefit payments.

- However, in no event will the Association be obligated to cover more than $300,000 in the aggregate for all benefits for any one life.

IMPORTANT DISCLAIMER

The Idaho Life and Health Insurance Guaranty Association does not provide coverage for all types of policies. In addition, coverage may be subject to substantial limitations or exclusions and require continued residency in Idaho. You should not rely on coverage by the Idaho Life and Health Insurance Guaranty Association in selecting an insurance company or an insurance policy.

Coverage is not provided by the Idaho Life and Health Insurance Guaranty Association for your policy or contract or any portion of it that is not guaranteed by the insurer or for which the risk is borne by you - the policyholder.

Insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any kind of insurance policy.

Idaho Life & Health Insurance Guaranty Association
3355 N Five Mile Rd #210
Boise, ID 83713
208-378-9510
www.idlifega.org

Idaho Department of Insurance
700 West State Street
P O Box 83720
Boise, Idaho 83720-0043
208-334-4250
1-800-721-3272
www.doi.idaho.gov

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RIDER APPLICABLE TO RESIDENTS OF IDAHO

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Hospital
   (a) A hospital that lacks organized facilities for operative surgery on the premises will be considered a hospital if it has facilities for operative surgery available to the hospital on a prearranged basis.
   (b) Benefits are payable for charges made by an Idaho state hospital for a confinement in an Idaho state hospital. Any exclusion regarding services given by persons who do not normally charge for their services does not apply to health services provided by the Idaho Department of Health and Welfare.

2. Discontinuance and Replacement of Coverage

This provision applies to a Insured Person if the Insured Person:
   (a) is eligible under this policy; and
   (b) was covered under the Participant Policyholder's former plan in effect within 60 days before the effective date of this policy; or
   (c) would not be covered under this policy because the Insured Person does not meet this policy's requirements for coverage.

The coverage in the Certificate replaces coverage under the former plan.
If the Insured Person was covered under the former plan on the date it ended, they will be covered under this policy on its effective date.
If the person is not covered under this policy because they do not meet this policy's requirements for coverage:
   (a) The following requirements under this Plan do not apply:
      - Any active work requirement.
      - Any requirement that the Insured Person must not be disabled.
   (b) Benefits under this policy for the Insured Person will be:
      - the same as those under the former plan.
      - reduced by benefits paid under the former plan.
   (c) If the Insured Person is disabled and extended benefits are payable under the former plan, no benefits are payable under this policy for the condition which caused the disability.
   (d) If the Insured Person remains disabled, benefits are payable under this policy until the earlier of the following:
      - 12 months from the date the former plan ended.
      - The date the benefits would otherwise stop under this policy.

No benefits are payable under this policy after the time periods shown above unless the Insured Person ceases to be disabled and meet all the requirements for coverage under this policy.
A Insured Person may have satisfied or partially satisfied a cash deductible under the former plan. Expenses counted toward the cash deductible under the former plan will be counted toward the cash deductible under this policy.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF
PROTECTION PROVIDED BY

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
    - $300,000 for death benefits
    - $100,000 for cash surrender or withdrawal values
- Health Insurance
    - $500,000 for health benefit plans*
    - $300,000 for disability insurance benefits
    - $300,000 for long-term care insurance benefits
    - $100,000 for other types of health insurance benefits
- Annuities
    - $250,000 for withdrawal and cash values
- The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plans benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

GREAT AMERICAN INSURANCE GROUP
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301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF ILLINOIS

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Definitions.

The definition for "injury" is revised as follows: Injury means physical Injury to an Insured Person caused by an Occupational Accident while coverage is in force under this Policy, which results directly and independent of disease and bodily infirmity. All Injuries sustained by an Insured Person in any one Accident shall be considered a single Injury.

The definition for "accident" is revised as follows: Injury or Injuries for which benefits are provided, mean accidental bodily injuries sustained by the insured person which are the direct cause of loss, independent of disease cause of loss, (independent of disease or bodily infirmity) and occurring while the insurance is in force.

The following definition for the word "intoxicant" is added to the list of definitions: Intoxicant means a chemical substance, such as alcohol, that causes euphoria, stupefaction, stimulation or excitement or that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.

2. Accidental Death and Dismemberment Benefits

Losses caused by botulism or ptomaine poisoning are covered as an accident.

3. Section VI Exclusions

To conform to Illinois Statute 215Ilcs 5/143:

"This Policy does not cover any Injury, Accident, expense, or loss caused in whole or in part by, or resulting in whole or in part from, any of the following:" is replaced with

"This Policy does not cover any Injury, Accident, expense, or loss caused in whole by, or resulting in whole from, any of the following:"

Exclusion 3 is replaced by the following verbiage to comply with 50 ILL. Adm. Code 2005:

3. any Pre-Existing Condition, unless the Insured Person has been covered under this Policy (or a substantially identical policy issued by the Company or another insurer, of which this policy is a renewal) for twelve consecutive months.

4. The following is added to Section VII Claims Provisions:

The Company will not reduce or deny your health claim if You give written proof of loss as soon as reasonably possible. Proof of loss must be given within one year from the time the Insured Person has to give proof.

This one-year limit does not apply:

(1) If the Insured Person is not legally able to do so.
(2) If the failure to give proof of loss is caused solely by the Insured Person's physical inability or mental incapacity due to a period of emergency hospitalization.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF PROTECTION PROVIDED BY THE

INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILIDGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July l, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(0), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental- only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health
Insurance Guaranty
Association
3502 Woodview Trace,
Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite
103
Indianapolis, IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILIDGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN **46204; (telephone) 317-232-2385.**

Insurance companies and agents are not allowed by Indiana law to use the existence of ILIDGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If **there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

GENERAL PURPOSES AND LIMITATIONS
OF THE KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001, et. seq.

DISCLAIMER

KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
3745 SW Wanamaker Road, Suite C
Topeka, KS 66610

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF KENTUCKY

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

MEDICAL EXAMS

If a medical exam is needed for proof of claim, The Insured Person will not have to pay for it.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(over)

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association, if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) Medicare Part C benefits or Medicare Part D benefits;

(8) certain unallocated annuity contracts (which give rights to group contract holders, not individuals) and certain structured settlement annuity contracts;

(9) Other exceptions and exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Association Law, Louisiana Revised Statutes R.S. 22:2081 *et seq.*

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than: $500,000 in health insurance benefits; $250,000 in present value of annuities (including cash surrender and cash withdrawal values); or $300,000 in life insurance death benefits (but not more than $100,000 in cash surrender and cash withdrawal values) - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

Effective Date: August 1, 2014

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF MARYLAND

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Continuous Total Disability Benefit
   The requirement that a Insured Person must be granted a Social Security Disability Award before benefits are payable is eliminated.

2. The following are added to the Accident Medical Expense Benefit:
   (a) Benefits for diagnostic or surgical procedures, excluding intraoral prosthetic devices, involving a bone or joint of the face, neck or head are payable on the same basis as benefits for the same diagnostic or surgical procedure involving any other bone or joint of the body.
   (b) The amount of benefits payable for prescription drugs is not based on the identity, the practicing specialty or the occupation of the Physician authorized to prescribe drugs.
   Benefits for prescription drugs filled by a mail order pharmacy are payable on the same basis as prescription drugs filled by any other pharmacy. The same limitations and amounts of any copayment or deductible apply to all pharmacies.
   (c) Skilled Home Health Care Benefits
   Benefits for Skilled Home Health Care given by a hospital licensed in Skilled Home Health Care or a Skilled Home Health Care Agency are payable on the same basis as the inpatient Hospital benefits, subject to the following limitations:
   - The care must be ordered and approved in writing by a Physician.
   - A Physician must supervise the continuing care of the person.
   - The Physician must certify that the person would need to be confined in a hospital or Skilled Nursing Facility if Skilled Home Health Care was not available.
     Payment will be made up to 40 visits each Calendar Year for the following services and supplies:
   - Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
   - Temporary or part-time care by a home health aide. The aide's primary duty must be caring for the patient.
   - Physical, occupational and speech therapy.
   - The following items will be covered to the extent that they would have been covered under the Policy if the person had been confined in a Hospital:
   - Medical supplies.
   - Drugs and medications ordered by a Physician.
   - Laboratory services given or ordered by a Hospital.
     Four consecutive hours of services of a home health aide will count as one visit. Each visit by any other member of the Skilled Home Health Care team will count as one visit.
     Services of a person who is a member of the Insured Person's family or who resides in their home are not payable under this benefit. Services or supplies given to a Person Eligible under Medicare are not payable under this benefit. A "Skilled Home Health Care Agency" is an agency or operation which provides a program of Skilled Home Health Care and which fully meets one of the following three tests:
   - It is approved under Medicare.
   - It is established and operated in accordance with the applicable licensing and other laws.

- It meets all of the following tests:
  - It has the primary purpose of providing a Skilled Home Health Care delivery system bringing supporting services to the home.
  - It has a full-time administrator.
  - It maintains written records of services provided to the patient.
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
  - Its employees are bonded and it provides malpractice insurance.

3. Section VI Exclusions
   (a) The following exclusion is added:
   No payment will be made for health care services furnished as the result of a referral prohibited by Section 1-302 of the Health Occupations Article of Maryland law.
   (b) The following item is added:
   Any exclusion of benefits for expenses which the Insured Person is not legally required to pay does not apply to charges made by a hospital owned or operated by the State of Maryland.

4. Subrogation
   This provision will not apply to medical payments payable without regard to fault under the Maryland Motor Vehicle Law.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland. The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
    - $300,000 in death benefits
    - $100,000 in cash surrender or withdrawal values
- Health Insurance
    - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
    - $300,000 for disability insurance
    - $300,000 for long-term care insurance
    - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
    - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
    - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.

- The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:
    - $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
    - $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation 9199

Reisterstown Road

P.O. Box 671—Suite 216C

Owings Mills, Maryland 21117

410-998-3907

Or,

Maryland Insurance Administration 200

St. Paul Place, Suite 2700 Baltimore,

Maryland.21202

1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guarantee
Association 4760 White Bear Parkway
Suite 101
White Bear Lake, MN 55110 Phone: (651) 407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant' s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no overage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

NOTICE OF PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health Insurance
Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

Missouri Department of Insurance,
Financial Institutions and Professional
Registration
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF MISSOURI

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Assignment of Benefits to Hospitals or Clinics

Benefits for services and supplies given in a public hospital or clinic are payable to that facility even if You have not assigned the benefits. The facility must make proper claim to the Company for the expenses. No benefits are payable to You to the extent benefits for the same expenses are paid to the facility.

2. Accidental Death and Dismemberment Benefit

The following losses are payable:

- Any loss caused by mental illness.
- Infection from the accidental swallowing of a contaminated substance.

3. Continuous Total Disability Benefit

(a) In no event will the minimum monthly benefit be less than $50.
(b) Any provision requiring the Insured Person to be under a Physician's care while disabled will not apply once the Insured Person has reached the maximum point of recovery from that accident.

4. The following is added to Section VII Claims Provisions:

If the Company asks for an autopsy, they will pay for it.

5. Subrogation

This provision does not apply to residents of Missouri.

6. Section II Effective Period is amended by the addition of the following:

(a) Except for non-payment of premium or for failure to meet the Company's underwriting requirements, the policy will not terminate before the first policy anniversary.
(b) The Company will provide 31 days' notice to the policyholder of their intent to end the policy.

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL: 1-800-643-7882.
If information is needed about the insurance, or should any dispute arise, call the Company at the toll-free number listed above, or write to the Company at the following address:

Great American Insurance Company, On Demand Claims
301 E. 4th Street/22nd Floor
Cincinnati, OH 45202

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF PROTECTION PROVIDED BY
MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies.

The maximum amount of protection with respect to any one (1) life, regardless of the number of policies or contracts, is:

Life Insurance
- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance
- $500,000 in basic hospital, medical and surgical or major medical benefits
- $300,000 for disability benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in net cash surrender and net cash withdrawal values

The Association may not cover this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Mississippi. You should not rely on coverage by the Association when selecting an insurer.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at **www.mslifega.org**, or contact:

Mississippi Life and Health Insurance
Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

NOTICE OF
PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Montana law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to hospital, medical, and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's web site at www.mtlifega.org or contact:

Montana Life and Health Insurance Guaranty Association PO Box 951 Oconomowoc, WI 53066-0951 877-678-1048 or administrator@mtlifega.org	Montana Department of Insurance State Auditor's Office 840 Helena Ave. Helena, MT 59601 406-444-2040

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance.
When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

Notice of Amendment and Adoption amending ARM 6.6.4601 and 6.6.4602, published in Montana Administrative Register 7/28/2011

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B) AND

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

IMPORTANT DISCLAIMER

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contact sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association 10
Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734

New Hampshire Department of Insurance 2
1 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261

SUMMARY:

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law and it does not in any way change one's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE:

Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under this Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

EXCLUSIONS FROM COVERAGE:

Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state; or
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or any entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health , or annuity benefits to its employees or members to the extent that the plan or program is self- funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with an insurance policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery; or
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.

LIMITS ON AMOUNT OF COVERAGE:

The Act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $300,000 in long-term care benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code, the Association will pay a maximum of $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

ADDITIONAL INFORMATION:

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

STATE FRAUD NOTIFICATIONS

IMPORTANT NOTICE

THIS FORM IS TO BE ATTACHED TO ALL APPLICABLE APPLICATIONS AND ENROLLMENTS FOR THE STATES LISTED BELOW:

FLORIDA STATUTE 817.234(1)(b)
"Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

NEW MEXICO STATUTE 59A-16C-8
"ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE OF PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance
Guaranty Association
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

Insurance Division
Public Regulation Commission
PO Box 1269
Santa Fe, NM 87504-1269
888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.

NMLIGA 10/12

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF NEW MEXICO

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

The following is added to Section VII Claims Provisions:

1. The Company is required to pay plan benefits directly to The New Mexico Department of Human Services if it has paid for any covered expenses through Medicaid.

2. In this situation, this method of benefit payment replaces any description of benefit payment shown in this provision.

3. A Notice to the Company must be attached to the claim form. Both forms must be submitted to the Company.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT
Effective October 1, 2013

Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in the state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association assesses its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Association when selecting an insurance company or when selecting an insurance policy.

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. **However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.**

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law's current coverages, exclusions and limits. The summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association. **Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.**

The Nevada Life and Health Insurance Guaranty Association
P. O. Box 3302
Reno, Nevada 89505

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, Nevada 89706

COVERAGE

Generally, individuals will be protected by the Association if they live in this state and **hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer.** The beneficiaries, payees or assignees of the insured persons are protected as well even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **NOT** protected by this Association if:

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside the state);
- the insurer was not authorized to do business in this state;
- their policy was insured by a nonprofit hospital or medical service organization, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **NOT** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26
  U.S.C. && 401, 403(b) and 457, respectively, or trustees of such a plan; or
- Medicare or Medicare Advantage contracts

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to life insurance policies on any one insured life, the Association will pay a maximum of $300,000, regardless of how many policies and contracts there are with the same company, and even if they provide different types of coverage. Within this overall

$300,000 limit, the Association will not pay more than $100,000 in cash surrender values, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to annuities, the Association will not pay more than $250,000 in the present value of benefits, including net cash surrender and withdrawal.

With respect to health insurance for any one life, the Association will not pay more than:
1) $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; 2) $300,000 for disability insurance or long term care insurance; or 3)
$500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $250,000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum coverage allowed is an aggregate of $250,000 in present-value annuity benefits including the value of net cash for surrender and net cash for withdrawal, regardless of the number of contracts issued by any one member company.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of $500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than
$5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

FOR MORE INFORMATION AND ANSWERS TO MOST ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION'S WEB SITE:

www.nvlifega.org

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF NEVADA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

Medical Transportation
Benefits for medical transportation are payable directly to the provider of the services. This applies only if the provider has not been paid from any other source.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street Third
Floor - Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS OF AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§40 I, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at: olhiga.org.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

RIDER APPLICABLE TO RESIDENTS OF OHIO

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's or Certificate's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

The following Fraud Warning is added to all applications or enrollment forms:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against Us, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION II, EFFECTIVE PERIOD, is amended as follows:

The **Policy Termination Date** provision is hereby deleted and replaced with the following:

Policy Termination Date. The effective period of this Policy will end at 12:01 A.M. Standard Time at this Policyholder's address on the earliest of:

1. this Policy Anniversary/Termination Date shown on the Schedule of Benefits page, unless renewed before that date;

2. the premium due date, if we do not receive a required premium payment, in full, on or before that date;

3. the date specified in any written notice of the Company's intent to terminate this Policy, which will be at least thirty-one (31) days after the date the Company sends such notice to this Policyholder's and/or Contractee's last known mailing address; or

4. the date specified in any written notice of the Policyholder's intent to terminate this Policy, which must be at least thirty-one (31) days after the date this Policyholder sends such notice to the Company.

Termination of this Policy will not affect any claim for a Covered Loss occurring prior to the effective date of termination. If premiums have been paid beyond the termination date, the Company will refund the excess.

SECTION VII, CLAIMS PROVISIONS, is amended as follows:

The **Time of Payment of Claims** provision is hereby deleted and replaced with the following:

Time of Payment of Claims. Benefits payable under this Policy, other than for loss for which this Policy provides for periodic payments, will be paid within thirty (30) days after the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

SECTION VII, CLAIMS PROVISIONS, is amended to include the following:

Appeals Process. If an Insured Person disputes a denial of benefits, he or she may request, in writing and within 30 days after the denial, an Independent Physician's examination. Such request should be made to Great American Insurance Company, On Demand Claims, 301 East Fourth Street, 22nd Floor, Cincinnati, OH 45202. The Company, at its own expense, shall provide the Insured Person with a list of three (3) Independent Physicians and the Insured shall have the right to choose the Independent Physician who will conduct the examination. If the Insured Person fails to make a selection within fifteen (15) calendar days after the date the list is provided, the Company shall have the right to either choose the Independent Physician to conduct the examination or determine eligibility of benefits based upon the results of a previous examination by an Independent Physician. Both parties agree to rely upon the results of the Independent Physician's objective examination. The Company has the right to suspend benefits if f the Insured Person fails to make or attend appointments with the Independent Physician or to submit to required objective examinations.

SECTION VIII, GENERAL PROVISIONS, is amended as follows:

The **Other Insurance** provision is hereby deleted and replaced with the following:

Other Insurance. If the Insured Person incurs losses for which benefits are payable under this Policy and any one or more similar policies issued by the Company or one of its affiliates, the coverage under this Policy shall be in excess of such other insurance, and will not contribute to such a loss with such other insurance. In the event other insurance as described exists and this coverage under this Policy is voided, all premium paid under this Policy shall be returned to the Insured Person or to the Insured Person's estate. This condition does not apply to other insurance which the Insured Person has procured and which was issued expressly to apply in excess of the coverage under this Policy.

The **Conformity With State Statutes** provision is hereby deleted and replaced with the following:

Conformity with State Statutes. Any provision of this Policy, which on the Policy's Effective Date is in conflict with the law of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum mandatory requirements of such law.

The Excess **Benefits provision** is hereby deleted in its entirety.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF
PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except with regard to health benefit plans for which the maximum amount of protection is $500,000 for each individual.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
400 NE 50th Street
Oklahoma City, OK 73105
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF OREGON

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Temporary Total Disability and Continuous Total Disability Benefits
   (a) Any reference to "under the care of a "Physician" is amended to read "under the care of a Physician when medically necessary".
   (b) Any requirement that the Insured Person be entitled to a Social Security Disability Award in order to receive or continue to receive benefits is eliminated. Any provision that payments will end if the Insured Person loses such award is also eliminated.

2. Payment for Ambulance Services
   Benefits for covered ambulance transportation services are payable to the provider of these services. No benefits are payable to the Insured Person to the extent benefits for the same expenses are paid to the provider.

3. Hernia
   Benefits will be payable for hernia if hernia is caused, directly and independently of all other causes, by an accident covered by the policy.

4. Subrogation
   This provision applies only to the Temporary Total Disability and Continuous Total Disability Benefits and the Accident Medical Expense Benefit.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association 290
King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; not does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;

- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;

- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the over-all $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more that $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, or $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $300,000, including any net cash surrender or withdrawal benefits.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF PENNSYLVANIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's or Certificate's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

The **Accidental Death Benefit** is hereby revised as follows:

The **Accidental Death Benefit** is not subject to an Incurral Period in Pennsylvania.

The **Temporary Total Disability Benefit** and **Continuous Total Disability Benefit** are revised to include the following:

Total Disability Benefits under this Policy will be reduced if the **Insured Person** is entitled to a weekly benefit through a policy which provides benefits in accordance with the Pennsylvania Motor Vehicle Financial Responsibility Law. In this case the **Insured Person** will be paid the amount less the benefit amount paid or available to the **Insured Person** under the first party income loss benefits of the other policy.

The **Pre-Existing Condition** definition is hereby deleted and replaced by the following:

Pre-Existing Condition means a disease or physical condition for which an **Insured Person** has received medical advice or treatment at any time during the 90 day period immediately preceding his or her effective date of coverage under this Policy.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

SUMMARY

COVERAGE, LIMITATIONS and EXCLUSIONS UNDER RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT ("Act")

A resident of Rhode Island who purchases life insurance, annuities, long-term care or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, # 426
Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue
Cranston, RI 02920
Tel. (401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act") can be found beginning at R.I. Gen. Laws section 27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE

The Association does **NOT** protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

LIMITATIONS ON COVERAGE

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance
- $300,000 for long-term care insurance
- $500,000 for basic hospital, medical, and surgical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. Sections 401, 403(b), or 457 covered by an unallocated annuity contract, or the beneficiaries of the each such individual if deceased;
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws section 27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF SOUTH CAROLINA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. Accidental Death and Dismemberment Benefits
   (a) If payment for death under any accident benefit should be made to a minor child or person, the Company may make the payment to an adult who is a relative by blood or marriage of that child or person only if that child or person is not competent to give a valid release.
   (b) The definition of loss of a hand for any accident benefit is amended to mean the loss of 4 entire fingers instead of the removal at or above the wrist joint.

2. The following is added to Section VII Claims Provisions:
Health claims, other than any disability income benefits, will be paid within 60 days after the Company receives proof of loss.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy.

South Dakota Life and Health Insurance Guaranty
Association Charles D. Gullickson, Executive Director
206 West 14th Street Sioux
Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance 1
2 4 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued)
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58 - 29 C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58 - 29 C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

NOTICE CONCERNING COVERAGE UNDER

THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value- $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009- $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
    - $100,000 for limited benefits and supplemental health coverages
    - $300,000 for disability and long term care insurance
    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
150 Third Avenue South
Suite 1600
Nashville, TN 37201

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

TENNESSEE NOTICE

under a Group Policy issued by Great American Insurance Company, Cincinnati, Ohio

NOTICE CONCERNING INSURANCE COMPLAINTS

Should You have any questions regarding the Insurance, You may contact Us at the following addresses.

Complaints other than claims:
Great American Insurance Company, On Demand
301 East 4th Street
Cincinnati, OH 45202-4201
(513) 369-5000

Complaints regarding claims
Great American Insurance Company, On Demand Claims
301 East 4th Street
Cincinnati, OH 45202-4201
1-833-444-0161

IMPORTANT NOTICE

HAVE A COMPLAINT OR NEED HELP?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you cannot work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Great American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Toll-free: 1-800-972-3008
Email: contactus@gaig.com
Mail: 301 E. 4th Street
Cincinnati, OH 45202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091
Austin, TX 78714-9091

¿TIENE UNA QUEJA O NECESITA AYUDA?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañia de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Great American Insurance Company

Para obtener información o para presentar una queja ante su compañia de seguros o HMO:

Teléfono gratuito: 1-800-972-3008
Correo electrónico: contactus@gaig.com
Dirección postal: 301 E. 4th Street
Cincinnati, OH 45202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091
Austin, TX 78714-9091

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF TEXAS

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

1. **Accidental Death Benefit**
   The clause: "The Company shall have the right to develop a structured benefit distribution plan for the payment of any benefit(s) payable under this policy, whether through an annuity or otherwise. We do not need the consent or agreement of the Insured Person, beneficiary, or any other person to develop and implement such a plan. Upon the purchase of an annuity, the obligation to make any and all future payments under this policy will be transferred to the company issuing the annuity. It is agreed that, in that event, the Insured Person or Designated Beneficiary will rely solely on that company to satisfy any and all further obligations for such benefits under this policy and no further demands or claims can or will be made against the Company for such benefits. If any person entitled to receive benefits is a minor or not competent to give a valid release, such benefits shall be paid to such person's legally appointed guardian or conservator." is replaced with the following: "At the option of the insured or their beneficiary(ies), the Company shall offer to develop a structured benefit distribution plan for the payment of any benefit(s) payable under this policy, whether through an annuity or otherwise. Upon the purchase of an annuity, the obligation to make any and all future payments under this policy will be transferred to the company issuing the annuity. It is agreed that, in that event, the Insured Person or Designated Beneficiary will rely solely on that company to satisfy any and all further obligations for such benefits under this policy and no further demands or claims can or will be made against the Company for such benefits. If any person entitled to receive benefits is a minor or not competent to give a valid release, such benefits shall be paid to such person's legally appointed guardian or conservator."

2. **Covered Accident Medical Service(s) means any of the following services:**
   "2. services of a Physician, a Registered Nurse, LPNs, BSNs, Nurse Practitioners, PAs, or other kinds of licensed nursing"

   is replaced with
   "2. a person acting in the scope of license as defined by Article 21.52 of the Texas Insurance Code."

3. **Covered Accident Medical Service(s) means any of the following services:**
   "8. Physical Therapy, Occupational Therapy, and Chiropractic Care, up to the Physical Therapy, Occupational Therapy and Chiropractic Care Maximum, if any, shown in the Schedule;" is removed.

4. **EXCLUSIONS**
   "16. any strike, boycott or stop-work action, whether or not the Insured Person participated in such strike, boycott, or stop- work action."

   is amended as follows:
   "16. any strike, boycott or stop-work action in which the Insured Person participated."

RIDER APPLICABLE TO RESIDENTS OF TEXAS

5. **The following Section VII Claim Provision is changed:**

Commutation of Losses. It is agreed that, at the Company's sole option, at any time later than two years from the date of any Accident resulting in a claim under this Policy, the Company may advise the Insured Person of its desire to be released from liability with respect to any such claim. In that event, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and the payment by the Company of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim.

is amended to read:
Commutation of Losses. It is agreed that, at the Company's sole option, at any time later than two years from the date of any Accident resulting in a claim under this Policy, the Company may advise the Insured Person of its desire to be released from liability with respect to any such claim. In that event, the Company will appoint an actuary or appraiser to investigate, determine and capitalize such claim, and an offer may be made by the Company for payment of the capitalized value of such claim. Should the Insured Person accept said offer, payment of the capitalized value of such claim will constitute a complete and final release of the Company with respect to such claim.

6. **The following is added to Section VII Claims Provisions:**
   (a) All benefits will be paid within 60 days after the Company receives satisfactory proof of loss.
   (b) The Company is required to pay Policy benefits to The Texas Department of Human Services if it has paid for any covered expenses through Medicaid.

In this situation, this method of benefit payment replaces any description of benefit payment shown in this provision A Notice to the Company must be attached to the claim form. Both forms must be submitted to the Company.

7. **The following wording is removed from Section VIII General Provisions.**

Excess Benefits. When an Insured Person has any Injury or loss to which both Accident Medical Expense coverage under this Policy and health care coverage under one or more other policies or plans applies, then the Accident Medical Expense benefit under this Policy shall apply only in excess of the benefits of the other policy or plan as described below, unless both: (1) the other policy or plan has coordination or excess benefits rules that require its benefits to be determined in excess of the benefits of this Policy; and (2) this Policy has covered the Insured Person longer than the other policy or plan has.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF UTAH

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

SECTION VII
CLAIMS PROVISIONS

In compliance with U.C.A. 31A-21-312 the Proof of Loss provision is amended to read:

Proof of Covered Loss. Written proof of covered loss must be furnished to the Company within ninety (90) days after the date of the Covered Loss. If the covered loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility and of the covered loss must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proofs within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than three years from the time proof is otherwise required. Failure to give notice or file proof of loss as required does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure. This subsection may not be construed to extend the statute of limitations applicable under Section **31A-21-313**

In compliance with U.C.A. 31A-21-313 the Sunset provision is amended to read:

Sunset. No claim by any Insured Person or beneficiary will be considered valid or collectible under this Policy unless full details of such claim have been presented to the Company within three (3) years from the date of the Accident which gives rise to such claim. Furthermore, unless by verified complaint it is alleged that prejudice to the complainant will arise from a delay in bringing suit against an insurer, which prejudice is other than the delay itself, no action may be brought against an insurer on an insurance policy to compel payment under the policy until the earlier of:

(a) 60 days after proof of loss has been furnished as required under the policy;

(b) waiver by the insurer of proof of loss; or

(c) the insurer's denial of full payment.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF VIRGINIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

The following provision is added:

Workers' Compensation: The Group Policy does not satisfy any legal requirement for Workers' Compensation Insurance. The Group Policy is not intended to provide coverage where Workers' Compensation Benefits are payable. If Workers' Compensation Benefits are found payable to a Insured Person for the same Injury for which benefits would be payable under the Group Policy, then no benefits shall be paid under the Group Policy for the Injury.
If benefits shall have been paid for the Injury, they shall be fully reimbursed to the Company by the Covered Person's employer or the employer's workers' compensation carrier without reduction for costs of collection or attorney's fees.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

VIRGINIA IN WITNESS CLAUSE

In return for the payment of premium, and subject to all the terms of the Policy, we agree with you to provide insurance as stated in this Policy.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

PROTECTION FOR YOU AND YOUR INSURANCE POLICY
THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

The Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48. 32 A RCW ("Act"). Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex officio, oversee the operation of the Association.

The expenses of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance Guaranty Association
P.O. Box 2292
Shelton, WA 98584
360-426-6744

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40259
Olympia, WA 98504-0259
360-725-7214

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance," as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance" (which includes long term care policies). Together, all of these policies and contracts are sometimes referred to as "covered policies," a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by

federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

3. WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:

- You are a Washington resident; or

- You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or

- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the time of entry of an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The Association generally cannot make an assessment f o r covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits $500,000

Disability Benefits and Health Benefits (including Long Term Care Benefits).....$500,000

Present Value of Individual Annuities .....

.....$500,000

Unallocated Annuity Contracts, other than certain government retirement plans
(limit is per contract owner or plan sponsor) $5,000,000

Government Retirement Plans in Unallocated Annuities established under Internal Revenue Code § § 401, 403(b), or 4 5 7
(limit is per participant) $100,000

This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

You should not rely on coverage under the Act when selecting an insurance company.

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This brochure has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by this brochure, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF WASHINGTON

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

Accidental Death and Dismemberment Benefits
The time limit within which loss must occur for the Accidental Death and Dismemberment Benefits in the Schedule will always be one year.

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF WISCONSIN

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's or Certificate's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.
The following Fraud Warning is added to all applications or enrollment forms:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

SECTION VII, CLAIMS PROVISIONS, is amended as follows:

Notice of Claims provision is hereby deleted and replaced with the following:

Notice of Claim. Written notice of claim must be received by the Company within 20 days after an Insured Person's Covered Loss, or as soon thereafter as reasonably possible. Failure to give notice of claim within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give notice within such time, provided such proof is furnished as soon as reasonable possible. Notice must be given by or on behalf of the claimant to the Company at Great American Insurance Company, On Demand Claims, 301 E. 4th St., 22nd Floor; Cincinnati, OH 45202, 1-833-444-0161, with information sufficient to identify the Insured Person.

Proof of Covered Loss provision is hereby deleted and replaced with the following:

Proof of Covered Loss. Written proof of a Covered Loss must be furnished to the company within ninety (90) days after the date of the Covered Loss. If the Covered Loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility and of the Covered Loss must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proofs within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, later than one year from the time proof is otherwise required for the Covered Loss.

SECTION VIII, GENERAL PROVISIONS, is amended as follows: Subrogation provision is hereby deleted and replaced with the following:

Subrogation. To the extent the Company makes a payment under this Policy and the person to whom or for whose benefit payment has been made has any right to recover from anyone liable for the Injury or death, the Company may assume the rights of the Insured and/or Designated Beneficiary/Survivor. The Company shall be reimbursed for any payments made to or on behalf of the Insured Person and/or Designated Beneficiary/Survivor only after such person has been made whole.

The Insured Person, Designated Beneficiary or Survivor must reimburse the Company for any payments the Company makes under this Policy, to the extent that Insured Person, Designated Beneficiary or Survivor receives payment from any party for the same Injury, Covered Loss, or death

In Witness Whereof, **We** have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

SUMMARY OF THE
WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT
(Effective July 1, 2019)

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurers for the money to pay the claims of covered persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. *However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.*

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have that are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816 Huntington, West Virginia 25712

West Virginia Insurance Commissioner Consumer Services Division
900 Pennsylvania Avenue
P.O. Box 50540
Charleston, West Virginia 25305-0540 (304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    i. multiple employer welfare arrangement;
    ii. minimum premium group insurance plan;
    iii. stop loss group insurance plan; or
    iv. administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;
- A contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also, for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300 ,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(1 O)) ; and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also, for any one insured life, the Guaranty Association will only pay a maximum of $300,000— no matter how many policies and contracts there were with the same company— for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under§§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

GREAT AMERICAN INSURANCE GROUP
Administrative Offices
301 E 4th Street
Cincinnati OH 45202-4201
513 369 5000 ph

(Herein called the Company)

RIDER APPLICABLE TO RESIDENTS OF WEST VIRGINIA

This Rider is attached to and made part of the Policy or one of its certificates as of the Effective Date shown in the Schedule of Benefits and applies only during the Policy's effective period. This Rider is subject to all of the provisions, limitations and exclusions of the Policy except as this Rider specifically modifies them.

Section VI Exclusions, exclusion 2, is amended to read as follows:

2. sickness, disease, or infection as the result of ptomaines;

In Witness Whereof, We have caused this Rider to be executed and attested, and, if required by state law, this Rider shall not be valid unless countersigned by our authorized representative.

President **Secretary**

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Wyoming who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Wyoming Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Wyoming Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Wyoming. You should not rely on coverage by the Wyoming Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for the purpose of sales or to induce you to purchase any kind of insurance policy.

The Wyoming Life and Health Insurance Guaranty Association
P.O. Box 36009
Denver, CO 80236-0009
(888) 959-4091
(303) 292-5022
Fax: (303) 292-4663

State of Wyoming
Department of Insurance
106 East 6th Avenue
Cheyenne, Wyoming 82002-0400
(800) 438-5768
(307) 777-7401
Fax: (307) 777-2446

The state law that provides for this safety-net coverage is called the Wyoming Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals).
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

LIMITS ON AMOUNT OF COVERAGE - EFFECTIVE 07/01/2012

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $500,000 limit, the Association will not pay more than $100,000 in cash surrender values for life insurance policies, $300,000 for basic hospital, medical and surgical insurance or major medical insurance, $300,000 for disability insurance, disability income insurance and long-term care insurance, $100,000 for coverages not defined as disability insurance or disability income insurance or basic hospital medical and surgical insurance or major medical insurance or long term care insurance, including any net cash surrender and net cash withdrawal values, $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or $300,000 in life insurance death benefits -again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.