UNIFIED LIFE INSURANCE COMPANY
P.O. Box 25326, Overland Park, KS 66213-5326
(Referred to in the Policy as the Company, We, Us, Our)

Policyholder: SPUR, ISD

State of Delivery: Texas

Policyholder Address: P. O. BOX 550, SPUR, TX 79370

Policy Effective Date: 08/01/2017

Expiration Date: 08/01/2018

Policy Number: 89117BA00S

ACCIDENT ONLY POLICY

We, UNIFIED LIFE INSURANCE COMPANY, agree with the Policyholder to insure, in accordance with the terms of the Policy, those Eligible Persons for whom the required premium is paid.

EFFECTIVE DATE AND POLICY TERM: This is a one-year non-renewable term Policy. The Policy takes effect on the Policy Effective Date, as stated above and in the Schedule of Benefits, and terminates at the expiration of the one-year term, except that Riders will terminate at the end of their term of coverage. All periods of insurance begin and end at 12:01 a.m. Standard Time at the Policyholder's address.

We have issued the Policy in consideration of the application by the Policyholder and payment of the required premium. It is subject to all of the terms, conditions and limits set forth in the Policy.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

The Policy is issued in and subject to the laws of the jurisdiction of the Policyholder's address.

Signed for Us at Our Administrative Office in Overland Park, Kansas.

William E. Buchanan

Chairman of the Board

Mary M. Rixey

Secretary

THIS IS A BLANKET ACCIDENT ONLY POLICY
READ IT CAREFULLY
BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS
THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY
REGULAR SEASON FOOTBALL EXCLUDED UNLESS ADDED BY RIDER

UNIFIED LIFE INSURANCE COMPANY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unified Life Insurance Company's toll-free telephone number for information or to make a complaint at:

800-366-8354

You may also write to Unified Life Insurance Company at:

Student Insurance
13931 Quail Pointe Drive
Oklahoma City, OK 73134

You may contact the Texas Department of Insurance to obtain information on companies, coverage's, rights or complaints at:

800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, Texas 78714-9104
FAX #: 512-475-1771
Web: http://www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al número de teléfono gratis Unified Life Insurance Company's para información o para someter una queja al:

800-366-8354

Usted tambien puede escribir a Unified Life Insurance Company:

Student Insurance
13931 Quail Pointe Drive
Oklahoma City, OK 73134

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de compañías, coberturas, derechos o quejas al:

800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, Texas 78714-9104
FAX #: 512-475-1771
Web: http://www.tdi.state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compañía primero. Si no se resuelva la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLÍZA: Este aviso es solo para propósito de informacion y no se convierte en parte o condición del documento adjunto.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
Lone Star Advantage

Policy Effective Date:	08/01/2017
Maximum Benefit:	$25,000.00 each Injury except Motor Vehicle Injury $5,000.00 each covered Motor Vehicle Injury
Deductible:	$ 0.00
Benefit Period:	52 weeks
Initial Treatment Period:	90 days

Premium:	Accident Only Policy:	$ 5,012.00
	Interscholastic Football Rider:	$ 7,518.00
	Total Single Premium:	$ 12,530.00

If an Injury to the Insured results in His incurring Covered Charges for any of the services specified below, We will pay the applicable benefit, subject to the Deductible and Coinsurance Percentage (if any), that are in excess of Covered Charges payable by any Other Valid and Collectible Insurance or Plan, including an ERISA or self-funded group policy. Provided medical treatment by a Doctor begins within the Initial Treatment Period, benefits will be payable for Covered Charges incurred during the Benefit Period up to the maximum benefit per service as shown below. The total payable for all Covered Charges shall never exceed the Maximum Benefit stated above. This excess provision will not apply to coverage provided under the Texas Children's Health Insurance Program (CHIP). Covered Charges exclude amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements. Usual and Customary Charges are based on data provided by Context[4] using the 75th percentile.

Inpatient	
Room & Board:	Private room rate
Intensive Care:	Private room rate (in lieu of Room & Board)
Hospital Miscellaneous:	Usual & Customary Charges up to $750.00 1st day, $250.00 per day thereafter/$5,000.00 maximum
Registered Nurse:	Usual & Customary Charges
Doctor Visits:	Usual & Customary Charges up to $40.00 per day (1 visit per day)
Family Travel:	$300.00 per day/5 days maximum
Outpatient	
Ambulatory Surgical Center:	Usual & Customary Charges up to $1,750.00 (facility charge)
Doctor Visits:	Usual & Customary Charges up to $40.00 per day (1 visit per day)
Physiotherapy:	$50.00 1st visit/$25.00 per visit thereafter up to 10 visits total (limited to 1 visit per day)
Medical Emergency:	Usual & Customary Charges up to $225.00 (for use of emergency room facility and services within 72 hours of Injury)
Medical Emergency Doctor:	Usual & Customary Charges up to $100.00
Shots and Injections:	Usual & Customary Charges up to $60.00 (within 24 hours of an Injury)
Diagnostic X-ray:	Usual & Customary Charges up to $225.00 and $50.00 for reading
CAT Scan/MRI/Bone Scan:	Usual & Customary Charges up to $750.00 and $50.00 for reading
Laboratory Procedures:	Usual & Customary Charges up to $100.00
Other (Inpatient and/or Outpatient)	
Surgeon:	90% of Usual & Customary Charges up to $4,500.00 (limited to primary procedure including removal of surgical implanted pins within two years of Injury)
Anesthetist:	25% of surgeon benefit
Assistant Surgeon:	25% of surgeon benefit
Ambulance:	Usual & Customary Charges up to $5,000.00
Dental Treatment:	Usual & Customary Charges up to $10,000.00 (benefits paid on Injury to Sound, Natural Teeth only)
Cosmetic Dental Benefit:	Usual & Customary Charges up to $1,000.00
Post Surgical Durable Medical Equipment:	Usual & Customary Charges up to $200.00
Eye Glasses, Contact Lenses and Hearing Aid Replacement:	Usual & Customary Charges (as a result of a covered Injury only)
Prescription Drugs:	Usual & Customary Charges
Post Surgical Orthopedic Braces & Appliances:	Usual & Customary Charges up to $500.00
Expanded Medical Benefit:	Pays for services per Schedule of Benefits up to $350.00

DEFINITIONS

Accident: A sudden, unforeseeable, external event which results in an Injury.

Ambulance: A vehicle which is licensed solely as an Ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another when the Insured is unable to travel to receive medical care by another means. Air Ambulance charges are only eligible for transportation from the site of an emergency to the nearest appropriate facility.

Ambulatory Surgical Center: A surgical or medical center, which has:

- permanent facilities for surgery; and
- an organized medical staff of Doctors and graduate registered Nurses [RN]; and is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed under the law.

Benefit Period: The number of days following the date of an Injury during which Covered Charges must be incurred, subject to the Initial Treatment Period. The Benefit Period begins on the date of Injury and ends on the last day of the Benefit Period. The Benefit Period is shown in the Schedule of Benefits.

Chronic Condition: A condition having a slow progressive course of indefinite duration with frequent recurrence over time.

Chronic Injury: Means repetitive motion injuries, overuse injuries, Chronic Conditions, shin splints, strains, tendonitis, stress fractures, and lumbago resulting from sports participation in a covered activity.

Company: Unified Life Insurance Company. Also hereinafter referred to as We, Us and Our.

Covered Charges: A service or supply listed in the Policy and which is performed or given for the treatment of an Injury.

Deductible: A dollar amount of Covered Charges an Insured must pay before We pay any benefits under the Policy. The Deductible is shown in the Schedule of Benefits.

Doctor: A legally qualified Doctor practicing within the scope of His license and recognized as a Doctor in the state where services are rendered. Doctor does not include a Relative or a person living with the Insured.

Durable Medical Equipment (DME): A device which:

- is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of Injury;
- is used exclusively by the Insured;
- is routinely used in a Hospital but can be used effectively in a non-medical facility;
- can be expected to make a meaningful contribution to the Insured's Injury; and
- is prescribed by a Doctor and the device is Medically Necessary for the Insured's rehabilitation.

Durable Medical Equipment does not include:

- comfort and convenience items;
- equipment that can be used by Family Members other than the Insured;
- health exercise equipment; and
- equipment that may increase the value of the Insured's residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to, modifications to the Insured's residence, property or automobiles such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Eligible Person: A registered student of the Policyholder participating in the Plan Selection indicated on the Policyholder's application.

DEFINITIONS (continued)

Experimental/Investigational: A drug, device, medical care or treatment will be considered experimental/investigational if:

- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- the informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- reliable evidence show that the drug, device, medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational are of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Covered Charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

"He", "Him" and "His" includes "She", "Her" and "Hers".

Hospital means a licensed institution that:

- has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Doctors:
  - laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Doctors;
  - permanent and full-time facilities for the care of overnight resident bed patients under the supervision of licensed Doctors;
  - 24-hour-a-day nursing service by graduate registered nurses; and
  - a patient's written history and medical records; or
- is accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital shall not include any institution used by the Insured as:

- a place for rehabilitation;
- a place for rest, or for the aged;
- a nursing or convalescent home;
- a long term nursing unit or geriatrics ward;
- an extended care facility for the care of convalescent, rehabilitative or ambulatory patients; or
- a psychiatric/substance abuse facility.

Hospital Confinement: A Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a charge is made by the Hospital.

Initial Treatment Period: The number of days following an Injury during which an Insured must seek initial treatment for an Injury. The Initial Treatment Period is shown in the Schedule of Benefits.

Injury: Bodily Injury which is:

- directly and independently caused by specific accidental contact with another body or object;
- unrelated to any pathological, functional, or structural disorder;
- a source of loss;
- results in non-participation of a covered activity to allow for healing; and
- sustained while the Insured is covered under the Policy.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of these Injuries, will be considered one Injury.

Injury does not include loss, which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

A written and signed Medical Release from a Doctor must be obtained by the Insured to continue to participate in a covered activity after sustaining an Injury. Failure to obtain a signed Medical Release will result in any subsequent Injury being denied.

If benefits have been paid under the Policy for an Injury and a subsequent Injury to the same body part as the original Injury is incurred within 120 days from the date of the last treatment of the original Injury, the subsequent Injury will be considered a continuation of the original Injury.

If benefits have been paid under the Policy for an Injury and a subsequent Injury to the same body part as the original Injury is incurred after 120 days from the date of the last treatment of the original Injury, the subsequent Injury will be considered a new Injury.

Insured: An Eligible Person for whom proper premium has been paid.

Interscholastic Football: The play or practice of Interscholastic Football under the supervision of a regularly employed coach or trainer. Coverage is restricted to regular season Interscholastic Football games and practices and Interscholastic Football play-off games and practices as defined and sanctioned by the state interscholastic governing body.

Medical Emergency: An Injury for which the Insured seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that without immediate medical care the Insured could reasonably expect that: (1) His life or health would be in serious jeopardy; (2) His bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Medical Emergency Doctor: Services rendered by a legally qualified Doctor practicing within the scope of His license and recognized as a Doctor in the state where services are rendered. Medical Emergency Doctor does not include a Relative or a person living with the Insured.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- is Experimental/Investigational or for research purposes;
- is provided solely for education purposes or the convenience of the Insured, the Insured's family, Doctor, Hospital, or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- can be safely provided to the patient on a less cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Medical Release: A written and signed statement from a Doctor that permits the Insured to continue to participate in a covered activity after sustaining an Injury.

Nurse: A professional, licensed, graduate registered Nurse (R.N.), a professional, licensed practical Nurse (L.P.N.) or a Certified Registered Nurse Anesthetist (CRNA).

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

- any individual, group, blanket, or franchise policy of accident, disability or health insurance, except an individual supplemental policy providing coverage for hospital confinement indemnity, a specified disease, or a limited benefit;
- any arrangement of benefits for members of a group, whether insured or uninsured;
- any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision by whatever terminology used including such benefits mandated by law of any motor vehicle insurance policy;
- any amount payable for services or injuries or diseases related to the Insured's job to the extent that he actually received benefits under a Worker's Compensation Law. If the Insured enters into a settlement to give up his or her rights to recover future medical expenses that would have been payable except for the settlement;
- Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to an Insured after he or she becomes disabled while insured hereunder; or
- any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Physiotherapy: Physical or mechanical therapy, diathermy, ultra-sonic therapy, heat treatment in any form, manipulation or massage administered by a Doctor.

Pre-existing Condition: A disease or physical condition for which the Insured received medical advice or treatment during the four months before the Insured's Effective Date of Coverage.

Prescription Drugs: Drugs, which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for an Insured's outpatient use.

Relative: A person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child).

School: The participating School or School district where the Insured is enrolled. The School must be a duly accredited or state certified, primary, elementary, or secondary School.

School-Sponsored Activity: A School authorized function:

- in which the Insured participates;
- which is organized by or under its auspices; and
- which is within the scope of customary activities for such entity.

This includes:

- classes and class trips under the direct supervision of qualified School authorities;
- summer School; and
- religious services or classes.

Sound, Natural Teeth: Natural teeth, the major portion of the individual tooth, which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Telehealth Service: A health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including compressed digital interactive video, audio, or data transmission; clinical data transmission using computer imaging by way of still-image capture and store and forward; and other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service: A health care service initiated by a physician or provided by a health professional acting under physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone for facsimile, including compressed digital interactive video, audio, or data transmission; clinical data transmission using computer imaging by way of still-image capture and store and forward; and other technology that facilitates access to health care services or medical specialty expertise.

Usual & Customary Charges: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate; or
- the charge which would have been made by the provider, Doctor, Hospital, etc. for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the five digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply. Usual and Customary Charges as used in the Policy to describe expense, will be considered to mean the payment system in effect at Policy issue as shown in the Schedule of Benefits.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are as defined in the Policy. This includes anyone who may become eligible while the Policy is in force. We reserve the right to request evidence of eligibility.

ALL SCHOOL ACTIVITIES AND ATHLETICS EXCLUDING INTERSCHOLASTIC FOOTBALL COVERAGE

Each Insured will be covered for Injury which occurs while the Insured is:

- on the School premises if participating in or attending any School-Sponsored Activity excluding participation in Interscholastic Football activities.
- away from the School premises if participating in or attending any School-Sponsored Activity excluding participation in Interscholastic Football activities.
- traveling directly, uninterruptedly and under the direct supervision of a qualified adult School authority to or from a School-Sponsored Activity excluding Interscholastic Football activities in a designated vehicle furnished by the School; or when traveling by other than a designated vehicle provided by the School, covered travel time shall not exceed one hour each way. This includes traveling to and from the Insured's home, School, or a School-Sponsored Activity excluding Interscholastic Football activities. The covered travel time includes the period before the Insured's required attendance time and the period after the Insured's dismissal or when He competes.

EFFECTIVE DATE

Insurance for an Insured will become effective on the later of:

- the Policy Effective Date; or
- the date He becomes an Eligible Person.

TERMINATION

Insurance for an Insured will end on the earliest of:

- the date He is no longer an Eligible Person; or
- the date the Policy terminates.

Termination will not affect a claim for a covered loss due to Injury, which occurred while coverage was in effect subject to the terms of the Policy.

MEDICAL EXPENSE BENEFITS

If an Injury to the Insured results in His incurring Covered Charges for any of the services specified in the Schedule of Benefits, We will pay the applicable benefit, subject to the Deductible and Coinsurance Percentage (if any), that are in excess of Covered Charges payable by any Other Valid and Collectible Insurance or Plan, including an ERISA or self-funded group policy. Provided medical treatment by a Doctor begins within the Initial Treatment Period, benefits will be payable for Covered Charges incurred during the Benefit Period up to the maximum benefit per service as shown in the Schedule of Benefits. The total payable for all Covered Charges shall never exceed the Maximum Benefit stated in the Schedule of Benefits.

This excess provision will not apply to coverage provided under the Texas Children's Health Insurance Program (CHIP). Covered Charges excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Charges include:

Ambulance: As noted in the Schedule of Benefits.

Ambulatory Surgical Center: In connection with outpatient day surgery, excluding non-scheduled surgery and surgery performed in a Hospital emergency room, trauma center, Doctor's office, or clinic. Benefits will be paid for services and supplies such as the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs or medicines, therapeutic services, and supplies.

Anesthetist: Benefits will be paid for the Doctor who performs the actual administration of anesthesia. No benefits will be paid for supervision of an anesthetist.

Assistant Surgeon: In connection with surgery if provided in the Schedule of Benefits.

Cat Scan/MRI/Bone Scan: As noted in the Schedule of Benefits.

Cosmetic Dental Benefit: Expenses incurred for services provided by dentists for the purpose of improving appearance when form and function are satisfactory and no pathologic conditions exist (i.e. implants, veneers, bonding and teeth whitening). Expenses as a result of a covered Injury will be covered as shown in the Schedule of Benefits. No other cosmetic surgeries or cosmetic dentistry, as determined by the Company, will be covered.

Dental Treatment: Performed by a Doctor of Medical Dentistry (DMD) or a Doctor of Dental Surgery (DDS), and made necessary by Injury to Sound, Natural Teeth.

Diagnostic X-ray: If so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays.

Doctor Visits (Inpatient): When Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

Doctor Visits (Outpatient): Benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy.

Expanded Medical Benefit: Expenses incurred for treatment of chronic sports conditions or injuries that are normally excluded under the Policy will be covered as shown in the Schedule of Benefits if they are aggravated by the Insured while participating in a covered sports activity. This benefit will terminate at 12:01 a.m. on the day after the covered activity ends, including post-season tournament play.

Eye Glasses, Contact Lenses and Hearing Aid Replacement: As noted in the Schedule of Benefits.

Family Travel means a daily benefit payable for travel by a Relative when the Insured has been Hospital Confined for five continuous days outside a 100-mile radius of the Insured's residence. Benefit is payable for each continuous day beginning with the sixth day of Hospital Confinement.

MEDICAL EXPENSE BENEFITS (continued)

Hospital Miscellaneous: While Hospital Confined, or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. If a specific benefit is designated in the Schedule of Benefits for any of these miscellaneous services, no benefits will be paid in excess of the maximum specified therein. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Intensive Care: Daily semi-private room rate when Hospital Confined, and general nursing care provided and charged for by the Hospital.

Laboratory Procedures: As noted in the Schedule of Benefits.

Medical Emergency: Use of the emergency room facility and services.

Medical Emergency Doctor: As noted in the Schedule of Benefits.

Physiotherapy: Benefits are limited to one visit per day.

Post Surgical Durable Medical Equipment: As noted in the Schedule of Benefits.

Post Surgical Orthopedic Braces & Appliances: When prescribed by a Doctor after surgery only. Replacement orthopedic braces and appliances are not covered. No benefits will be paid for orthopedic braces and appliances used to protect an Injury which allows an Insured to participate in covered sports activities.

Prescription Drugs: As noted in the Schedule of Benefits.

Registered Nurse: Private duty nursing care only, while Hospital Confined and ordered by a licensed Doctor. General nursing care provided by the Hospital is not covered under this benefit.

Room & Board: Daily semi-private room rate when Hospital Confined, and general nursing care provided and charged for by the Hospital.

Shots and Injections: As noted in the Schedule of Benefits.

Surgeon: Surgeon's fees for surgery. Payment will be made as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.

ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT BENEFITS

If, within 180 days from the date of an Accident covered by the Policy, Injury from such Accident results in one of the specific Losses listed below, the Insured or beneficiary may request Us to pay the Benefit Amount opposite such Loss in lieu of payment under the "Medical Expense Benefits" provision. If the Insured sustains more than one such Loss as the result of one Accident, only the largest will be applicable.

LOSS	BENEFIT AMOUNT
Loss of Life	$20,000.00
Loss of Both Hands	$20,000.00
Loss of Both Feet	$20,000.00
Loss of Entire Sight of Both Eyes	$20,000.00
Loss of One Hand and One Foot	$10,000.00
Loss of One Hand and Entire Sight of One Eye	$10,000.00
Loss of One Foot and Entire Sight of One Eye	$10,000.00
Loss of One Hand	$5,000.00
Loss of One Foot	$5,000.00
Loss of Entire Sight of One Eye	$5,000.00
Loss of Thumb and Index Finger of Same Hand	$ 500.00

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye or eyes. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of a thumb and index finger of the same hand means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand) from the same Accident.

"Severance" means the complete separation and dismemberment of the part from the body.

MANDATED BENEFITS

Telemedicine Medical Service and Telehealth Service: Benefits will be paid for services provided through Telemedicine Medical Service and Telehealth Service on the same basis as services provided through a face-to-face consultation. Benefits shall be subject to all Deductible, co-payment, coinsurance, limitations, or any other provisions of the Policy.

Brain Injury: Benefits will be paid the same as any other Injury for Medically Necessary services required for and related to a brain Injury to facilitate the recovery and progressive rehabilitation of survivors of acquired brain Injuries to the extent possible to their pre-injury condition. Acquired brain Injury is defined as a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Coverage will not be denied based solely on the fact that treatment or services are provided at a facility other than a Hospital. Treatment may be provided at a facility at which appropriate services may be provided, including: a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation hospital; or an assisted living facility regulated under Chapter 247, Health and Safety Code.

The therapies listed and defined below shall be considered:

- **Cognitive rehabilitation therapy:** Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured's brain-behavioral deficits.
- **Cognitive communication therapy:** Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- **Neuro-cognitive therapy:** Services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.
- **Neuro-cognitive rehabilitation:** Services designed to assist cognitively impaired Insureds to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- **Neuro-behavioral testing:** An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the Insured, family, or others.
- **Neuro-behavioral treatment:** Interventions that focus on behavior and the variables that control behavior.
- **Neuro-physiological testing:** An evaluation of the functions of the nervous system.
- **Neuro-physiological treatment:** Interventions that focus on the functions of the nervous system.
- **Neuro-psychological testing:** The administering of a comprehensive battery of tests to evaluate neuro-cognitive, behavioral, and emotional strengths and weaknesses and their relationship with normal and abnormal central nervous system functioning.
- **Neuro-psychological treatment:** Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- **Psycho physiological testing:** An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- **Psycho physiological treatment:** Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- **Neuro-feedback therapy:** Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

- **Remediation:** The process (es) of restoring or improving a specific function.

- **Post-acute transition services:** Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

- **Community reintegration services, including outpatient day treatment services:** Services that facilitate the continuum of care as affected individual transitions into the community.

- **Other post-acute treatment services:** Advanced rehabilitation services provided through an interdisciplinary team approach. Services are based on an assessment of the individual's cognitive deficits, with a treatment goal of achieving functional changes in a patient with brain injury by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms. Services include cognitive rehabilitation services, behavior management and the development of coping skills and compensatory strategies.

- **Reasonable expenses for periodic reevaluation**: Reasonable charges for periodic reevaluation of the care of an Insured who: has an acquired brain injury; has been unresponsive to treatment; and becomes responsive to treatment at a later date. A determination of reasonable expenses may include consideration of: cost; the time expired since the last evaluation; any difference in the expertise of the health care practitioner performing the evaluation; changes in technology; and advances in medicine.

Diagnosis or Treatment of Temporomandibular Joint: Benefits will be paid for Covered Charges for diagnostic and surgical procedures for treatment of the temporomandibular (jaw) joint if the treatment is necessary as the result of an accident. No benefits are provided for any other services or supplies for treatment or related services to the temporomandibular (jaw) or jaw-related neuromuscular conditions, including oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alternation of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for: a) loss or expense caused by, contributed to, or resulting from: or b) treatment, services or supplies for, at, or related to:

- Acupuncture.
- Air travel except while as a fare-paying passenger on a regularly scheduled commercial air carrier; travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including, but not limited to, two or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; snowmobile or off-road motorized vehicle not requiring licensing as a motor vehicle.
- Artificial aids such as eyeglasses, contact lenses, hearing aids, or examinations or prescriptions therefore unless specifically provided for in the Schedule of Benefits.
- Chronic Conditions, degenerative conditions, overuse injuries, repetitive motion injuries, stress fractures, tendonitis, bursitis, shin splints, strains, Osgood-Schlatters, spondylolysis, osteochondritis, osteomyelitis, and lumbago unless specifically provided for in the Schedule of Benefits.
- Cosmetic surgery of any kind, except reconstructive surgery as a direct result of a covered Injury.
- Dental treatment, except for accidental Injury to Sound, Natural Teeth.
- Elective Surgery or Elective Treatment.
- Food poisoning or bacterial infections (except an infection occurring through an open visible wound); cysts or skin lesions such as blisters or boils; tumors; over-exerting (not to include heat stroke); rhabdomyolysis; fainting; hernia, regardless of how caused; illness or disease in any form.
- Immunizations, preventive medicines or vaccines, except where required for treatment of a covered Injury.
- Intoxicants and narcotics. The Company is not liable for any loss sustained or contracted in consequence of the Insured being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a Doctor.
- Injury for which benefits are paid or payable by workers' compensation or employer's liability or occupational disease law.
- Injury where the Insured is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
- Nuclear reactions or radiation contamination; war, declared or undeclared; participation in a riot or civil disorder; or while a member of the Armed Services.
- Orthodontics (braces) for any reason, damage to, or loss of orthodontics.
- Orthopedic appliances used to protect an injury which allows an Insured to participate in athletic activities.
- Pre-existing Conditions or aggravation of a Pre-existing Condition, as defined.
- Routine physical examinations and routine testing, preventive testing or treatment, screening exams or testing in the absence of Injury.
- Skiing, scuba diving, surfing, roller skating, ice skating, or riding in a rodeo.
- Skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planning, bungee jumping, bob-sledding, or ballooning.
- Suicide or attempt thereat, while sane or insane (including drug overdose); intentionally self-inflicted Injuries; fighting.
- Supplies, except as specifically provided in the Policy.
- While committing or attempting to commit an assault or felony, or to which a contributory cause was the Insured being engaged in an illegal occupation.
- Participation in Interscholastic Football during the months of August through December unless such coverage is specifically added by rider.

GENERAL PROVISIONS

Entire Contract, Changes: The Policy, the attached Policyholder's application and the Insureds' enrollment forms (if any) constitute the entire contract of insurance. All statements made in the application or an enrollment form shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application or enrollment form and a copy of the application has been furnished to the Policyholder, the Insured, or the Insured's beneficiary, if any.

No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

Payment of Premium: All premiums are payable in advance for each Policy term in accordance with the Company's premium rates. Premiums are payable to Unified Life Insurance Company, P.O. Box 269065, Oklahoma City, Oklahoma 73196-9065. In the event the Policyholder ceases operations during the Benefit Period, the Company will refund the unearned portion of the premium to the Policyholder.

Notice of Claim: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the beneficiary to Unified Life Insurance Company, P.O. Box 304, Duncan, Oklahoma 73534-0304, or to any authorized agent of the Company, with information sufficient to identify the Insured shall be deemed notice to the Company.

Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be furnished to Unified Life Insurance Company, P.O. Box 304, Duncan, Oklahoma 73534-0304, in case of claim for loss within 90 days after the date of such loss. 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, later than one year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under the Policy for any loss will be paid immediately but in no event later than 60 days after the Company receives due written proof of such loss.

Payment of Claims: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Insured or the estate of the Insured.

If any indemnity of the Policy shall be payable to an Insured who is a minor or otherwise not competent to give a valid release or to the estate of the Insured, the Company may pay such indemnity to any Relative by blood or connection by marriage of the Insured who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Physical Examination and Autopsy: The Company at its own expense shall have the right and opportunity to: 1) examine the person of any Insured when and as often as it may reasonably require during the pendency of a claim hereunder; and 2) to have an autopsy made in case of death unless prohibited by law.

Legal Actions: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Subrogation: The Company shall be subrogated to all rights of recovery which any Insured has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Right of Recovery: Payments made by the Company which exceed the Covered Charges (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear.

Right to Appeal: If the Company has denied a claim for benefits, in whole or in part, then a repeal request may be submitted in writing within 90 days from the date of the notice of claim denial. The Company will review the initial decision and send a written determination within 60 days of receipt of the appeal request.

Payment to State: Benefits will be payable to the Texas Department of Human Services for Covered Charges under the Policy for an Insured when the Texas Department of Human Services pays for such expenses and notification is given to the Company with the claim. Benefits payable on behalf of a child under the Policy will be paid to the Texas Department of Human Services after the Company receives written notice that:

- the parent who purchased the coverage is: (a) a possessory conservator of the child under an order issued by a court in this state or is not entitled to possession of or access to the child; and (b) is required by court order or court-approved agreement to pay child support;
- the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and
- the Company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the Company that benefits must be paid directly to the Texas Department of Human Services.

Benefit Payments to Parent of a Minor: Benefits will be payable to a managing conservator responsible for an Insured minor child provided such managing conservator has paid all or any portion of a medical bill that would be covered under the terms of the Policy. The managing conservator of the Insured minor child must provide a certified copy of a court order establishing the person as managing conservator or other evidence designated by the State Board of Insurance before the benefits can be paid to the managing conservator. The managing conservator must also submit valid receipts and invoices for such medical payments on behalf of the Insured minor child.

UNIFIED LIFE INSURANCE COMPANY
P.O. Box 25326, Overland Park, KS 66213-5326

INTERSCHOLASTIC FOOTBALL COVERAGE RIDER

All of the terms and conditions of the Policy to which this Rider is attached, unless inconsistent herewith, shall apply with regards to coverage hereunder.

INTERSCHOLASTIC FOOTBALL COVERAGE

Each Insured will be covered for Injury which occurs while the Insured is:

- actually engaged, as an official representative of the Policyholder, in the play or practice of Interscholastic Football under the supervision of a regularly employed coach or trainer of the Policyholder.

- actually being transported in a designated vehicle provided by the School as a member of a group under the direct supervision of a qualified adult School authority of the Policyholder for the purpose of participating in the above mentioned Interscholastic Football competitions.

Except that coverage is restricted to regular season Interscholastic Football games and practices and Interscholastic Football play-off games and practices as defined and sanctioned by the state interscholastic governing body. Football spring training, football summer passing league, and football off-season workouts are not included under the coverage. Injury sustained during off-season scrimmages is not covered.

Coverage becomes effective on the date specified by the state interscholastic governing body as the first official day of practice for Interscholastic Football. Coverage expires the last day of the calendar year, December 31st, 2017.

This Rider terminates on the earliest of:
- last day of the calendar year, December 31st, 2017; or
- the date the Policy terminates.

UNIFIED LIFE INSURANCE COMPANY

William E. Buchanan — Chairman of the Board

Mary M. Rixey — Secretary

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. 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.state.tx.us

INFORMACION IMPORTANTESOBRECOBERTURABAJO LAASOCIACIONTEXASLIFEYHEALTHINSURANCEGUARANTY
(Para aseguradoresdeclaradosinsolventes o menoscabados en o despuésdel 1 de septiembrede 2011)

La ley de Texas estableceunsistemaparaprotegertenedores de pólizassisucompañíade seguro devida o de saludquebra. La AsociaciónTexas LifeyHealth Insurance Guaranty (la"asociación) administraestesistema de protección. Sólo los tenedroes de pólizas de seguroquienes son miembros de la asociación son elegiblesparaestaprotección la cualessujeto alos terminos, limitacionesycondiciones de la ley asociación.(Seencuentra la ley en el Texas Insurance Code, Capitulo 463.)

Esposibleque la asociación no cubrasupóliza entotal o en parte a causa de limitacionesestatuarias.

Elegibilidadparaprotecciónporla asociación

Cuandounacompañía de seguromiembrose estádeclaradoinsolventey estásometidoa un ordende liquidaciónporunacorte o clasificadocomomenoscabadopor el Comisionado deSeguro de Texas, la asociación prove cobertura a lostenedores depólizasquienes son:

- ResidentesdeTexas a la vez(**sinconsideracióna la residencia deltenedorde póliza altiempode emitir delapóliza**)
- Residentesdeotrosestados,SOLO silascondicionessiguentesexisten:
  1. El tendedorde polizatieneunapóliza con unacompañíaquedomicilia enTexas;
  2. El estado de residencia del tenedor de pólizatieneunaasociacióngarantía similar;y
  3. El tenedor de pólizano eselegibleparacoberturaporla Asociacióngarantiadelestado de residencia del tenedor depóliza.

Limites de protecciónporlaAscociacón

Accidente,Accidente ySaludoSegurodeSalud:
- Para cadaindividuocubiertobajouna o máspólizas: hasta unasuma de $500.000 USD paraseguro de hospital básico, médico-quirúgico,y"majormedical", $300.000 USD paraseguro de incapacidad o cuidado a largo plazo,y$200.000 USD paraotrostipos de seguro desalud.

Segurodevida:
- Valor de rescate de efectivonetoretirado hasta unasumade $100.000 USD bajouna o máspólizas en solo unavida;o
- Indemnizaciónporfallecimiento hasta unasuma de $300.000 USD bajouno o máspólizas en solo unavida; o
- Beneficiostotales hasta unasuma de $5.000.000 paracualquierdueño de pólizas multiples de vida de tipo no-grupo

Anualidadesindividuales:
- Valor actual de beneficios hasta unasumade $250.000USD bajouno o máscontratos de solo unavida.

Anualidaddegrupo:
- Valor actual de beneficiosasignados hasta unasuma de $250.000 USD en solo unavida; o
- Valor actual de beneficiosasignados hasta unasuma de$5.000.000 USD parauntenedor de contratosin tener en cuenta el número de contratos.

Limitetotal:
- $300.000 USDen sólounavida con laexcepcióndellimitede $500.000 USD paraseguro de salud, el limitede $5.000.000 USD parasegurode vida,yel limite de $5.000.000 USD de anualidadde grupono asignado.

Compañías de seguro ysusagentes seestánprohibidosporleydeusarlaexistenciade laAsociaciónpara elpropósitodevender,solicitaroincentivoparacomprarcualquiera forma de seguro. Cuandose necesitaseleccionarunacompañíadeseguro, no se debedepender de la cubertura de laAsociación. Para preguntasadicionalessobre la protección delaAsociaciónoinformacióngeneralsobreunacompañíadeseguro,por favor use la información decontactosiguiente.

TexasLifeandHealthInsurance GuarantyAssociation
515 CongressAvenue, Suite 1875
Austin, Texas 78701
800-982-6362orwww.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas78714-9104
800-252-3439or www.tdi.state.tx.us

Rev. 02/2012

FACTS	WHAT DOES UNIFIED LIFE INSURANCE COMPANY (UNIFIED LIFE) DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and insurance claim history Income and checking account information Medical information and employment information When you are no longer our customer, we continue to share your information as described in this notice.

How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Unified Life chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Unified Life share?	Can you limit this sharing?
For our everyday business purposes-- Such as to process your transactions, maintain your accounts(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— To offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes— Information about your transactions and experiences	No	We don't share
For our affiliates' everyday business purposes— Information about your creditworthiness	No	We don't share

Questions?	Call 800-237-4463 or go to www.unifiedlife.com

What we do	
How does Unified Life protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Unified Life collect my personal information?	We collect your personal information, for example, when you ▪ Pay insurance premiums or file an insurance claim ▪ Pay us by check or provide employment information ▪ Give us your wage statements.
Why can't I limit all sharing?	Federal law gives you the right to limit only ▪ Sharing for affiliates' everyday business purposes-information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Unified Life has no affiliates
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ Unified Life does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ Unified Life does not jointly market.

Other important information
Unified Life maintains suitable physical and electronic safeguards to protect your non public information. Our procedural safeguards are reviewed and updated annually to further ensure the security of your information. All physical and electronic files are kept in secure areas. Access to your non public information is restricted to only those employees who need access to your information in order to provide service to you. Our employees are trained annually on the importance of confidentiality and their responsibility for your privacy.