Policy Form 9F149F-CL

Accident & Sickness Plan

A Non-Renewable Term Policy

Designed for

SAINT XAVIER UNIVERSITY

2009 • 2010

Underwritten by

COLUMBIAN LIFE
INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
P.O. BOX 1381 • BINGHAMTON, NY 13902-1381

SERVICING AGENT:

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

AIP International, Inc.
28085 Ashley Circle, Suite 201
Libertyville, IL 60048-9658
Phone: (800) 452-5772
Fax: (847) 281-8813

Email: **office@aipinternational.com**
Website: **www.saintxavierinsurance.com**

Form No. 3743-CL-09-IL U-40IL

For assistance and questions about Insurance Benefits, ID cards, or problems:
Associated Insurance Plans International, Inc.
Post Office Box 189
Libertyville, Illinois 60048
Phone: (800) 452-5772
Email: **office@aipinternational.com**
website: **www.saintxavierinsurance.com**

For assistance and questions about claim status and claim processing:
Student Assurance Services, Inc.
Post Office Box 196
Stillwater, MN 55082
www.sas-mn.com
Phone: 1-800-328-2739

How can I find a Beech Street Provider?
Beech Street Preferred Provider Network
www.beechstreet.com
Phone: 1-800-432-1776

How can I find an Express Script Pharmacy?
www.express-scripts.com
Phone 800-332-5455

Columbian Life Insurance Company Accident & Sickness Plan for Saint Xavier University

2009 • 2010

This is a general summary of Student Accident and Sickness Insurance coverage. Keep this brochure for your records as no individual policy will be issued. This summary is not a contract; however, the Master Policy is available for review online at: **www.saintxavierinsurance.com**.

Note: The Master Policy contains the contract provisions and shall prevail in the event of any conflict between the brochure and the Master Policy.

INTRODUCTION

Saint Xavier University is making available to students and their dependents a plan of Blanket Accident and Sickness Insurance Plan (hereinafter called "plan" or "Plan") underwritten by Columbian Life Insurance Company. It provides continual protection, 24 hours a day, anywhere in the world during the period of coverage for which you have paid the proper premium.

- The maximum benefit is $250,000 per Accident or Sickness.
- Benefits are subject to a policy year deductible of $300, which is waived for covered treatment at the Student Health Center.
- Covered treatment paid at 100% at the Student Health Center.
- Beech Street Preferred Provider Network Providers may be accessed throughout the United States, with the exception of Hawaii. If you obtain medical treatment from a Beech Street provider, you will receive a higher reimbursement towards your covered medical expenses.
- Express Scripts drug card to $1,500 per policy year subject to copayments of $15 for generic medications; $25 for brand medications.
- Benefits for Wellness and Immunizations
- Monthly automatic payment option for Dependents

ELIGIBILITY

The University requires health insurance coverage for all undergraduate students and scholars under the age of 70.
Students or scholars will automatically be enrolled in the health insurance plan and the premium will be charged to the student/scholar's account each semester, unless proof of existing health insurance coverage is provided to the University. Students/scholars who have existing health insurance coverage or another plan for paying medical expenses, must complete the Waiver Form online at **www.saintxavierinsurance.com** by the Waiver Deadline Dates shown on page 3.

Health insurance coverage is also available to Graduate Students on a voluntary basis. Students who wish to enroll in the health insurance plan must enroll by the Enrollment Deadline Dates shown below.

Students must be physically and actively attending classes to enroll in this health insurance plan. Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of their Effective Date of coverage shall not be covered under this health insurance plan. Contact Associated Insurance Plans International at (800) 452-5772 or email **office@aipinternational.com**.

The Plan Administrator reserves the right to determine if the student has met the Eligibility requirements. If the Plan Administrator later determines the Eligibility requirements have not been met, its only obligation is to refund the premium.

PERIOD OF COVERAGE AND WAIVER DEADLINE DATES FOR UNDERGRADUATES/SCHOLARS

Term	Date Coverage Begins	Date Coverage Ends	Waiver/Enrollment Deadline Date
Fall 1	08-11-2009	12-31-2009	09-08-2009
Fall 2	10-03-2009	12-31-2009	10-23-2009
Spring/Summer 1	01-01-2010	08-10-2010	01-26-2010
Spring/Summer 2	03-01-2010	08-10-2010	03-11-2010
Summer	05-19-2010	08-10-2010	06-13-2010

PERIOD OF COVERAGE AND ENROLLMENT DATES FOR GRADUATE STUDENTS AND DEPENDENTS OF ALL STUDENTS

Term	Date Coverage Begins	Date Coverage Ends	Enrollment Deadline Date
Annual	08-11-2009	08-10-2010	09-30-2009
Fall	08-11-2009	12-31-2009	09-30-2009
Spring/Summer	01-01-2010	08-10-2010	02-15-2010
Summer	05-19-2010	08-10-2010	06-15-2010

IMPORTANT: We do not accept enrollment forms and premium payments received after the Enrollment Period Deadline Date, unless you qualify for late enrollment.

2009-2010 PREMIUM RATES

	Annual	*Fall Installment	*Spring&Summer Installment
Student Only	$ 1,216	$ 608	$ 608
Additional for Spouse	$ 2,432	$ 1,216	$ 1,216
Additional for Each Child	$ 1,824	$ 912	$ 912

	**New Students Spring/Summer	Summer	Monthly
Student Only	$ 829	$ 329	$ 112
Additional for Spouse	$ 1.621	$ 667	$ 213
Additional for Each Child	$ 1,216	$ 503	$ 162

***** The Fall and Spring/Summer Installment method of payment is only available for students purchasing Annual Coverage.

******For new students not previously eligible to enroll for Annual or Fall insurance coverage.

Note: An administrative fee has been added to all student rates except Annual.

COVERAGE FOR DEPENDENTS

Students who enroll in the plan may also enroll their eligible dependents by the Enrollment Deadline dates shown on page 3. Dependents must enroll when the student first enrolls in the plan and must enroll for the same coverage as the student.

LATE ENROLLMENT FOR DEPENDENTS

Students may enroll dependents after the enrollment period deadline date only if there is a qualifying event. Qualifying events include involuntary loss of coverage under another health plan, marriage, birth or adoption of a child or dependent arriving from a foreign homeland. **You must enroll in this plan within 31 days of the qualifying event.** Students must notify Associated Insurance Plans International, Inc at **office@aipinternational.com**.

HOW TO ENROLL FOR COVERAGE

Graduate Students and Dependents of All Students:

OPTION 1 - Enroll Online - Credit Card or Electronic Check payment only

Students can complete an online Enrollment Form on the website **www.saintxavierinsurance.com.**

OPTION 2 - Enroll Offline - Mail Enrollment Form and Payment

1. Students can download and print an Enrollment Form on the website **www.saintxavierinsurance.com.**
2. Print all information legibly and indicate the coverage and options you desire.
3. Enclose your check payable to Student Health Insurance, or complete all credit card information.
4. Send the form and payment to Student Insurance Plan, Associated Insurance Plans International, Inc. P.O. Box 189, Libertyville, IL 60048.

Note: If you are not paying premium for the entire year, to avoid a lapse in coverage your premium payment must be received within 31 days after the date your coverage expires for the term of coverage you have selected. A premium due notice will be mailed to the address provided, however it is your responsibility to make timely premium payments regardless of whether or not you receive a premium due notice.

Call (800) 452-5772 or email office@aipinternational.com for payment terms and information.

AUTOMATIC DEBIT FOR MONTHLY PREMIUMS

Monthly premium payment option is available for annual coverage with an automatic debit from your banking or credit card account. Students must complete the Authorization Form and return it with an Enrollment Form by the Fall Enrollment Deadline Date.

Students who elect monthly premium payment option whose coverage lapses (because of insufficient funds), will not be permitted to continue the monthly premium payment option and will be required to wait until the next enrollment period to reapply for benefits.

For monthly premiums, your account will be debited on the 11th of each month through July 11, 2010.

EFFECTIVE AND EXPIRATION DATES OF COVERAGE

Student and dependent coverage under the Policy becomes effective on the later of the following dates:

- The Policy Effective date August 11, 2009 at 12:01 a.m.;
- The first day of the Term for which the proper premium has been paid; or
- 12:01 a.m. following the date the proper premium is received by the Servicing Agent.

Student and dependent coverage under the Policy will expire on the earliest of the following dates:

- The Policy Expiration date August 10, 2010 at 11:59 p.m.; or
- When payment for your Accident and Sickness coverage is due and unpaid.

Dependent coverage under the Policy becomes effective on the same date as the Insured Student for which the proper dependent premium payment is received. Coverage will not be effective prior to that of the Insured Student. Dependent coverage will expire on the date the Student's coverage expires or the date the dependent no longer meets the definition of a dependent.

PREMIUM REFUND POLICY

All premium refund requests must be made in writing and include any proof and date of occurrence. Refund requests should be sent to Associated Insurance Plans International, Inc. at P.O.Box 189, Libertyville, IL 60048 or by email: **office@aipinternational.com**.

A prorated refund will only be issued for the following situations:

- Students who withdraw from school within 31 days following the Effective Date of coverage, unless medical benefits have been paid during the first 31 days; or
- Students who have entered into full-time active duty military service for any country; or
- Students who are non-immigrant Foreign Nationals who have left the North American Continent.

CONTINUOUS COVERAGE

There will be no lapse in coverage for students and their dependents who were:

- covered to the policy termination date of the University's prior student health insurance plan; and
- enroll and pay the premium for coverage under this policy within 31 days of the expiration date of the prior student health insurance plan.

Students and their dependents will not be denied benefits under this Policy for a Pre-existing Condition or an Injury or Sickness covered under the student's prior student health plan, unless:

- This Policy specifically excludes the Injury or Sickness expenses, or
- This policy limits the benefits payable for the Injury or Sickness Expenses, or

The Injury or Sickness is subject to any lifetime maximum, and the maximum is exhausted.

CONTINUATION OF COVERAGE

If a student who has been covered under this health insurance plan graduates or leaves school, whether voluntarily or involuntarily, the student and their previously insured dependents may continue to be covered under this health insurance plan for the remainder of the policy year at the cost of insurance shown.

If a student is ineligible to continue coverage under the health insurance plan, continuation of coverage may be available for up to 9 months, provided an application is made within 31 days of the policy expiration date. The cost of insurance for the Continuation Plan must be paid in advance for the entire continuation period selected. No re-enrollment is permitted once the original term of coverage selected has expired. Please contact Associated Insurance Plans International, Inc. at (800) 452-5772 or email **office@aipinternational.com.**

SCHEDULE OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum Medical Expense Benefit - Per Accident or Sickness	$250,000	$250,000
Deductible: Per Person – Per Accident or Sickness	$ 300	$ 300
Student Health Center: The Deductible does not apply when covered services are received at the student Health Center (SHC)	100%	N/A
Prescription Drug Card (Express Scripts)- $1,500 per Policy Year Generic Drug: *$15 co-payment* Brand Name: *$25 co-payment*	N/A	N/A

HOSPITAL INPATIENT COVERED SERVICES AND BENEFIT LIMITS	IN-NETWORK	OUT-OF-NETWORK
(a) Hospital Room and Board and Hospital Miscellaneous: $100 copay per confinement	80%	60%
(b) Surgical Treatment:	80%	60%
(c) Anesthesia : 30% of Surgical Treatment	N/A	N/A
(d) Assistant Surgeon: 30% of Surgical Treatment	N/A	N/A
(e) Private Duty Nurse: Paid under (a)	80%	60%
(f) Physician Non-Surgical Visits: 1 visit per day; not paid day of surgery	80%	60%
(g) Physiotherapy: 1 visit per day; Paid under (a)	80%	60%
(h) Maternity Benefits: Benefits paid the same as any Sickness	80%	60%
(i) Mental & Nervous Disorders: Benefits paid the same as any Sickness; up to $10,000 per Policy Year; $50 copay per confinement	80%	60%
(j) Substance Abuse: Benefits paid the same as any Sickness; up to $10,000 per Policy year	80%	60%
(k) PreAdmission Testing:	80%	60%

OUTPATIENT COVERED SERVICES AND BENEFIT LIMITS	IN-NETWORK	OUT-OF-NETWORK
(a) Hospital Outpatient Surgical Miscellaneous: Day Surgery	80%	60%
(b) Surgical Treatment:	80%	60%
(c) Anesthesia: 30% of Surgical Treatment	N/A	N/A
(d) Assistant Surgeon: 30% of Surgical Treatment	N/A	N/A
(e) Physician Non-Surgical Visits: 1 visit per day, not paid the day of surgery; $20 copay per visit	80%	60%
(f) Physiotherapy: Includes occupational therapy; 1 visit per day, $20 copay per visit; up to 10 visits	80%	60%
(g) Diagnostic X-rays, Radiology, and Laboratory Services: $25 copay per visit; includes Ultrasound and Nuclear medicine, ECG, EEF and other Electronic Diagnostic procedures	80%	60%
(h) Hospital Emergency Room: $100 copay per visit (waived if admitted)	80%	60%
(i) Maternity: Paid the same as any Sickness; includes Abortion if life threatening to mother	80%	60%
(j) Mental and Nervous Disorders: $20 copay per visit; up to 20 visits per Policy Year	80%	60%
(k) Substance Abuse: $20 copay per visit; up to 20 visits per Policy Year	80%	60%
(l) Prescription Drugs: 30 day supply per prescription; $15 copay per Generic Drug; $25 copay per Brand Drug; Refer to Prescription Drug Program through Express Scripts to $1,500 per Policy Year	N/A	NA

OTHER COVERED SERVICES AND BENEFIT LIMITS	IN-NETWORK	OUT-OF-NETWORK
(a) Ambulance: up to $300	N/A	N/A
(b) Dental Treatment: Xray and treatment of dental injury to sound, natural teeth	80%	80%
(c) Orthopedic Appliances and Durable Medical Equipment: up to $200 per Policy Year	80%	60%
(d) Motor Vehicle Injury: Benefits paid the same as any Injury	80%	60%
(e) Home Health Care: 40 visits per Policy Year; $50 Deductible/Policy Year, up to maximum $300 per Policy Year.	80%	60%
(f) Consultant Physician: when requested by the attending Physician	80%	60%
(g) Well Child Care: includes immunizations and age appropriate screening tests; subject to Deductible	80%	60%
(h) Immunizations: when received at Student Health Services only; $200 per Policy Year; $10 copay per immunization	100%	N/A
(i) Wellness Benefit: up to $300 per Policy Year; subject to Deductible	80%	60%
(j) Additional Benefits Mandated by State of Illinois:		
Breast Reconstruction following Mastectomy and Post Mastectomy Treatment Benefits	80%	60%
Cervical Pap and Prostrate Cancer Tests Benefit	80%	60%
Diabetes Benefit	80%	60%
Mammography Examination Benefit	80%	60%
HPV Vaccine	80%	60%
Maternity and Postpartum Care Benefit	80%	60%
Temporomandibular Joint Disorder And Craniomandibular Disorder Benefit	80%	60%

ADDITIONAL PROGRAMS

OPTIONAL DENTAL, VISION AND PHARMACY *DISCOUNT CARD* See Details Page 20
A separate dental, vision and prescription drug discount plan is available on an optional basis and is subject to payment of an additional premium. Please call (800) 452-5772 to request plan details or visit our website at **www.SaintXavierinsurance.com** and click on Dental, Vision, & Pharmacy-*Discount Card*.

OPTIONAL DENTAL AND VISION *INSURANCE* PLAN
A separate dental insurance plan with optional vision coverage. Several benefit options to choose from, subject to additional premium. Please call (800) 452-5772 to request plan details or visit our website at **www.SaintXavierInsurance.com** and click on Dental *Insurance Plan.*

SCHOLASTIC EMERGENCY SERVICES (Travel Assistance) See Details Page 10

ASK MAYO CLINIC See Details Page 10

Note: These Additional Programs are not underwritten by Columbian Life Insurance Company.

ADDITIONAL PROGRAMS

(These programs are not underwritten by Columbian Life Insurance Company)

SCHOLASTIC EMERGENCY SERVICES, INC. (TRAVEL ASSISTANCE)

Students who enroll and maintain medical coverage in this health plan are eligible for Scholastic Emergency Services, Inc. administered by Assist America. This program provides 24-hour assistance services whenever the student is traveling more than 100 miles away from home, school, or abroad.

All assistance services must be arranged and provided by Assist America, no claims will be accepted for assistance services provided any other provider or company.

Note: This program does not replace medical insurance. All claims for medical expenses should be submitted to Student Assurance Services Inc. for consideration.

The Assist America program meets or exceeds the requirements of USIA for International Students and Scholars. The following services are provided:

1. Medical Consultation and Evaluation. Your call to the Alarm Center is evaluated by medical staff and referred to the appropriate provider.
2. Hospital Admission Guarantee - outside the U.S.A.
3. Emergency Evacuation. If adequate medical facilities are not available, whatever mode of transportation equipment and personnel necessary will be used to evacuate you or your family member to the nearest facility capable of providing proper care.
4. Critical Care Monitoring. Scholastic Emergency Services will stay in regular communication with the attending physician and/or hospital and relay information to your family.
5. Medically Supervised Repatriation. If you or your dependent is ready to be discharged from the hospital but is still in need of medical assistance, you will be repatriated to a rehabilitation facility or home, and if necessary will be provided a medical or non-medical escort.
6. Dispatch of Prescription Drugs. If you or a dependent forgets or loses a medication, a replacement will be arranged. If the medication is not available locally, the medicine will be dispatched when possible and legally permissible.
7. Transportation to Join Patient. If you are traveling alone and will be hospitalized for more than 7 days, transportation to the place of hospitalization will be provided for a designated family member or friend.
8. Care for Minor Children. If a minor child is left unattended as a result of an accident or illness, one-way transportation (with attendant if necessary) will be provided to the place of residence.
9. Return of Mortal Remains. In case of death, transport and reasonable assistance in legal formalities will be provided for the return of mortal remains.
10. Legal Referrals. Referrals for interpreters or legal personnel are available.

If you require assistance, call Assist America at toll free inside the U.S. 800-872-1414 or outside the U.S. 609-986-1234 or email at medservices@assistamerica.com.

ASK MAYO CLINIC

Students and eligible dependents who enroll and maintain medical coverage in this health plan have access to a 24-hour nurse line administered through the Mayo Foundation. This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for a sickness or injury. Appropriate care may include self-care at home, a call to a Physician, or visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries. This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefits questions. Health benefit questions should be referred to Student Assurance Services, Inc. The *Ask Mayo Clinic* 24-hour nurse line toll free number will be provided with your ID card.

BEECH STREET CORPORATION PREFERRED PROVIDER NETWORK

Persons insured under this health insurance plan may choose to be treated within, or out of, the Beech Street Preferred Provider Network. The Beech Street Preferred Provider Network consists of hospitals, doctors, and other health care providers, which are organized into a network for the purpose of delivering quality health care at a discounted fee. Providers may be accessed throughout the United States, with the exception of Hawaii. If you obtain medical treatment from a Beech Street provider, you will receive a higher reimbursement towards your covered medical expenses. When an Insured Person uses the services of a Beech Street provider, the covered expenses incurred will be payable at 80% of the PPO Allowance. However, when treatment is rendered by providers outside the Beech Street Preferred Provider Network, expenses will be payable at 60% of the Usual and Customary covered charges.

Exception: Benefits will be paid at the 80% of PPO Allowance when 1) the insured person cannot reasonably obtain the services of a Beech Street PPO provider, due to an Emergency Medical Condition; 2) the covered service is performed by a non-PPO ancillary provider who is a radiologist, anesthesiologist, pathologist or other similar ancillary provider; or 3) the covered service is not available from a Beech Street PPO provider due to insufficient number, type, or distance and the Insured has made a good faith effort to utilize Beech Street PPO providers for a covered service.

In order to use the services of a Beech Street participating provider, you must present your Student Accident and Sickness Insurance Identification Card.

A complete listing of Beech Street participating providers is available on the web at: **www.saintxavierinsurance.com** or by calling toll free to Beech Street Preferred Provider Network (800) 432-1776. The participation of individual providers is subject to change without notice. It is your responsibility to confirm a provider's participation when calling for an appointment or at time of visit.

EXPRESS SCRIPTS PRESCRIPTION DRUG PROGRAM

When the physician prescribes a drug for a covered Injury and Sickness, the student can purchase the Prescription Drug at a Participating Pharmacy by showing their ID card to the pharmacy as proof of coverage. The student pays a Copay based on the type of Prescription Drug purchased; Copay amounts are listed in the Benefits Schedule. For a complete listing of participating pharmacies visit:

www.saintxavierinsurance.com or
www.express-scripts.com.

Coverage questions on a specific drug can be obtained from Express Scripts at 800-332-5455 or visiting their website.

Excluded drugs and medicines under the Prescription Drug Program include, but are not limited to:

- Over the counter drugs and medicines.
- Drugs purchased outside the US which are not legal inside the US.
- Drugs not approved by the FDA for any use/indication in the US.
- Medical Supplies or devices, including Insulin prescribed needles, syringes, test scripts.
- Charges for the administration or injection of any drug or medicine.
- Injectible medication not designed for patient administration
- Serums and toxoids and vaccines.
- A drug or medicine dispensed or administered while hospital confined, including any confinement any facility or institution that dispenses drugs.
- Vitamins and minerals; Growth hormones; Drugs for weight loss; Drugs for smoking cessation purposes; Drugs solely for cosmetic purposes.

Important - You will receive your Identification Card for the Pharmacy Drug Program directly from Express Scripts approximately 2 weeks after the waiver deadline date for each semester. Until your permanent Identification Card is received, you must present the Express Scripts Temporary Identification Card (found by going to "More Online Services" at **www.saintxavierinsurance.com** to your Pharmacist. You may also call 800-452-5772 and ask that a copy of the Temporary Identification Card to be sent to you.

EXPLANATION OF BENEFITS

PRE-CERTIFICATIONS AND REFERRALS

This health plan does not require pre-certification or referrals for any covered service prior to the date the service is performed. Covered services will be evaluated for benefits when the claim is submitted to Student Assurance Services Inc. for payment.

COINSURANCE, COPAY, AND DEDUCTIBLE MAXIMUM

Covered services are subject to co-insurance, co-pay, and deductible unless indicated otherwise, up to the Benefits Schedule Policy Year Maximum of $250,000 per Accident or Sickness.

Copay is the amount the Insured person must pay to the Physician or Hospital for each procedure, office visit, or confinement, each time he or she receives a covered service, including prescription drugs.

Deductible is the amount subtracted from eligible expenses for each Accident or Sickness before benefits are considered. Each insured person must satisfy the deductible.

Coinsurance is the percentage of covered expense the health plan pays. After the deductible is satisfied, the Plan will pay a coinsurance of 80% of the Network Provider's Allowable fee; and for Non-Network Providers a coinsurance of 60% of Usual and Customary charges for eligible expenses, as a result of a covered Accident or Sickness.

MATERNITY EXPENSE BENEFIT

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

With respect to Covered Services for Maternity, benefits will be provided the same as any Sickness for an Insured and her newborn child for:

1. a minimum of 48 hours of inpatient care following a vaginal delivery; and
2. a minimum of 96 hours of inpatient care following a caesarean section.

Benefits may be provided for a shorter length of inpatient stay for services related to maternity and newborn care if the attending Physician determines in accordance with the protocols and guidelines developed by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists that the mother and her newborn meet the appropriate guidelines for length of stay based upon evaluation of the mother and the newborn. In this instance Covered Services will include one post-discharge physician office visit or one in-home nurse visit, to verify the condition of the newborn in the first 48 hours after hospital discharge.

We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Schedule of Benefits.

BENEFITS MANDATED BY THE STATE OF ILLINOIS

This policy will pay benefits for state mandated benefits in accordance with any applicable Illinois law. Benefits may be subject to policy deductibles, coinsurance, limitations or exclusions. Description of these state mandated benefits can be found in the Master Policy on internet site: **www.saintxavierinsurance.com.**

Students may also refer any questions to the claim administrator, Student Assurance Services, Inc. at 800-328-2739.

PRE-EXISTING CONDITION

This policy does not cover any injury or sickness for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately prior to the student or dependent's Effective Date of Coverage.
A pre-existing condition is subject to a 12 month pre-existing condition waiting period. During this waiting period, the student or dependent must be continuously covered under this health plan for 12 consecutive months. The pre-existing condition waiting period must expire before benefits for a pre-existing condition will be considered for payment under this health plan.
If any break in continuous coverage occurs, the pre-existing condition exclusion will apply.

Provisions that Reduce or Eliminate the Pre-existing Condition Waiting Period:

- If a student or dependent had 12 months of continuous coverage under a prior student health plan, the injury or sickness which began during the prior year coverage will not be considered a pre-existing condition.
- The pre-existing condition waiting period will be reduced by the period of time a student or dependent was covered by Prior Creditable Coverage, if such coverage was continuous (no break in coverage for 63 days or more to a date immediately prior to the effective date of coverage under this Policy). You must show proof of Prior Creditable Coverage by submitting a Certificate of Prior Coverage from the prior plan or other satisfactory evidence of coverage.
- The pre-existing condition waiting period does not apply to pregnancy, newborn or adopted children.

Prior Creditable Coverage means Your prior Student health insurance policy of the Policyholder or other coverage provided in the United States under any of the following: a group health plan; health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract; Medicare; Medicaid; military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the Federal Employee Health Benefits Program; a public health plan; or a health benefit plan of the Peace Corps. Prior Creditable Coverage does not include prior coverage before a break in coverage. A break in coverage occurs when an individual does not have health coverage for 63 or more continuous days.

EXCLUSIONS

This Policy does not provide Benefits for expense resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
2. Dental treatment, except as specifically provided in the Schedule of Benefits.
3. Treatment where no Injury or Sickness is involved (physical examinations or preventive medicines) except as specifically provided in the Schedule of Benefits; or Elective Surgery and Elective Treatment; or Abortion; It does not include cosmetic surgery made necessary by Injury. Non-medical self-care or self-help training; health or fitness club memberships; personal comfort or convenience items; treatment for Hirsutism, hair growth or baldness.
4. Motor vehicle accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan. The Motor Vehicle Injury Benefit Limit is shown on the Schedule of Benefits.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations; Treatment for foot care including care of flat

feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices.
6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Growth Hormone therapy; Patient Controlled Analgesia; Allergy Treatment.
8. Injury sustained while participating in the practice or play of interscholastic sports or Intercollegiate Sports, including the participation in any practice or conditioning program for such sport, contest or competition.
9. Intentional self-inflicted Injuries, including drug overdose; Loss incurred while committing or attempting to commit a felony; Loss due to voluntary participation in a riot or civil disturbance.
10. Routine newborn baby care, well baby nursery and related Physician's charges, except as specifically provided in the Schedule of Benefits.
11. Services provided normally without charge by the Health Service of the Policyholder; or by any person employed or retained by the Policyholder; or services covered or provided by the student health fee.
12. Treatment related to nicotine addiction or smoking cessation.
13. Use of any services or supplies which are experimental and/ or not in accord with generally accepted standards of medical practice; organ transplants, including donor's expenses; Services.
14. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.
15. Pre-existing Conditions, not subject to Credit for Prior Coverage, until continuously covered by the Policyholder's Student Accident and Sickness Insurance plan for a period of 12 months.
16. Weight management services and supplies related to weight reduction programs, weight management program, and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat, and for weight reduction or treatment of obesity.

DEFINITIONS

Accident means accidental bodily injuries which are the direct cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force.

Dependent means the insured Student's spouse; or Domestic Partner; or Student's unmarried natural child (including step children if dependent on the insured Student or child for whom the insured Student is a legal guardian) under the age of twenty-three (23) years who is not self supporting. This provision also includes a child for whom the insured Student is a legal guardian, if the child is dependent on the insured Student.

Dependent also includes a child over the age of 23 who is incapable of self sustaining employment because of a handicapped condition, and is chiefly dependent upon the insured Student for maintenance and support. Proof of a Dependent's incapacity or dependence shall be requested by Us within 60 days of a child's attainment of the limiting age. If the requested proof is not received within 31 days of Our inquiry coverage may terminate when the Dependent reaches the limiting age. In the absence of any such inquiry by Us, the Dependent's coverage will continue until otherwise terminated as provided in this Policy. We may request subsequent proof of incapacity or dependency no more than once every year. This provision applies whether the Dependent is dependent on parents or Other Care Provider for lifetime care and supervision. Other Care Provider includes Community Integrated Living Arrangement, group home, supervised apartment and other residential services licensed or certified by Illinois.

A newborn child of the insured Student will be covered from birth until 31 days old. Coverage for such child will be for a Sickness and Injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage at the end of the 31 days will expire. To continue coverage past

the 31 days, the Insured must enroll the newborn child within 31 days of birth and pay the required additional premium starting from the date of birth.
A child for whom the insured Student has a legal obligation for the purposes of adoption, will be covered from the date the legal obligation begins until 31 days after the date the legal obligation began. Coverage for such child will be for Sickness and Injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage at the end of the 31 days will expire. To continue coverage past the 31 days, the Insured must enroll the adopted child within 31 days from the date legal obligation began, and pay the required additional premium starting from the date the legal obligation began.

Benefits for routine well newborn or adoption child care expenses are covered, if the insured Student enrolls the child and pays the additional premium within 31 days from the date of birth or the date the legal obligation began.

Domestic Partner means a person who meets at least three of the following five conditions: (a) the person resides with the insured Student; (b) the person and insured Student hold common or joint ownership of the residence or of the lease for the residence; (c) the person and insured Student have joint ownership of a motor vehicle; (d) the person and insured Student have a joint checking account; and/or (e) the person must be designated as a beneficiary under the insured Student's life insurance coverage and/or identified as a primary beneficiary in the insured Student's will. To obtain coverage as a domestic partner, the insured Student and domestic partner must submit a written "Affidavit of Domestic Partnership" to the Policyholder's Student Health Center and to the Plan Administrator. In the Affidavit, the insured Student and domestic partner must attest that they are each other's sole domestic partner, that they have agreed to be responsible for their common welfare. They must also indicate which three of the five qualifying conditions have been met.

Elective Surgery and Elective Treatment means surgery or medical treatment which is not necessitated by a pathological change occurring after Your Effective Date of coverage or not covered under the policy. Elective Surgery and treatment includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; cosmetic procedures; submucous resection and/or other surgical correction for deviated nasal septum; allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight management services.

Experimental and Investigational means any treatment, procedure, drug or device which (a) cannot be lawfully marketed without approval of the federal food and drug administration, (b) is determined to be experimental, investigational or for research purposes based on the informed consent document or the written protocols used by the treating Physician, Hospital or facility, (c) is subject to ongoing Phase 1 or Phase 2 clinical trials, (d) reliable evidence show the prevailing opinion among experts is that further studies or clinical trials are necessary, and (e) the outcomes data published in peer-reviewed medical and scientific literature is insufficient to substantiate its safety and effectiveness as compared with the standard means of treatment for the Injury or Sickness.

In making these determinations, the Plan Administrator will obtain an external evaluation by an appropriately licensed or qualified professional who will review the claim and any additional information provided for review.

Hospital means an institution duly licensed as a hospital in the state in which it is located and operating within the scope of such license. A Hospital must have inpatient facilities, staff of Physicians available at all times, 24-hour a day nursing services, and accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This does not include a facility primarily designed for use as an extended care facility, convalescent nursing home or skilled nursing facility. Hospital for Mental and Nervous Disorders and Substance Abuse includes facilities licensed by the state to provide inpatient Mental Nervous or Substance Abuse services or treatment in the state it is located.

Hospital Confined/Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which Benefits are payable.

Injury or Injuries means accidental bodily Injury or Injuries which are the direct cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force. All related Injuries and recurrent symptoms of the same or similar condition will be considered one Injury.

Loss means medical expense or indemnity covered by this Policy as a result of any one Injury or Sickness.

Medical Emergency means a life threatening medical condition resulting from an Injury or Sickness of the Insured, which arises suddenly and required immediate medical care to prevent permanent disability or loss of life to the Insured.

Medically Necessary means those Covered Services provided or prescribed by a Hospital or Physician which are: (a) consistent with the symptoms and diagnosis or treatment of the Sickness or Injury and which could not have been omitted without adversely affecting the quality of care rendered, (b) in accord with standards of generally accepted medical practice, (c) not provided solely for education purposes or primarily for the convenience of You or Your Physician, (d) the most appropriate supply or level of service which can safely be provided to You, and (e) within the scope, duration, or intensity of the level of care needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is not maintenance or preventive care.

Other Medical Coverage means any plan providing benefits or services for medical care or treatment, where such benefits or services are provided on a group basis by or under: group insurance; coverage provided by hospital or medical service organizations such as Blue Cross or Blue Shield or similar pre-paid medical service organizations; union welfare or trust plans; employer or employee benefit plans or arrangement whether on an insured or uninsured basis; Medicare as established by Title XVIII of the United States Social Security Act of 1965, as amended; any medical benefits coverage in group, group-type and individual automobile “no-fault” and traditional automobile “fault” type coverage; HMO (health maintenance organization); or PPO (preferred provider organization).

Orthopedic Appliances or Durable Medical Equipment: Any supportive appliance or device which (i) is prescribed by a Physician; (ii) is primarily and customarily used to serve a medical purpose; (iii) can withstand repeated use; (iv) generally is not useful to a person in the absence of Injury or Sickness; and (v) is used exclusively by the Covered Person. Replacement braces and appliances are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include for example: non-prescription therapy devices or medical supplies; comfort and convenience items; modifications of the Covered Person’s residence, property or automobiles; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted. We reserve the right to determine whether an Orthopedic Appliance or Durable Medical Equipment is eligible as a Covered Service.

Sickness means Your bodily sickness, mental sickness, or Maternity which is not a Pre-existing Condition and which causes Loss while Your coverage is in force. Sickness includes pregnancy, Complications of Pregnancy and trauma related disorders due to injuries which otherwise do not meet the definition of an Injury. All related sicknesses and recurrent symptoms of the same or similar condition will be considered one Sickness.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which you are legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Ingenix for such services or supplies.

RIGHT OF REIMBURSEMENT

If an Insured incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) the health plan has the right to reimbursement for all benefits paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise, by the Insured, the Insured’s parents if the Insured is a minor, or the Insured’s legal representative as a result of that Sickness or Injury; and (b) the health plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid for that Sickness or Injury.

The health plan shall have the right to first reimbursement out of all funds the Insured, the Insured’s parents, if the Insured is a minor, or the Insured’s legal representative, is or was able to obtain for the same expenses paid as a result of that Sickness or Injury. The Insured is required to furnish any information or assistance or provide any documents that the health plan may reasonably require in order to obtain their rights under this provision. This provision applies whether or not the third party admits liability.

EXCESS COVERAGE

When there is a basis for a claim under this health plan and Other Medical Coverage, benefits must be paid by Other Medical Coverage first before benefits are paid under this health plan. When submitting a claim for payment, include the Other Medical Coverage’s explanation of payment with any itemized bills to Student Assurance Services, Inc.

CLAIM PROCEDURE

Send all medical, pharmacy or hospital itemized bills including diagnosis to the address below within 90 days of the date of the Injury or Sickness or as soon as reasonably possible. Information to identify the student or dependent must be provided and includes: student name, patient name, address, student ID number or social security number, and name of the Institution under which the student is insured.

A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. A company claim form can be obtained from the Servicing Agent website **www.saintxavierinsurance.com** or Student Assurance Services website **www.sas-mn.com**. A student may also complete the online claim form from the website.

Bills submitted later than one year after the 90 days will not be considered for payment except in the case of no legal capacity.

Send claims or inquiries to:
Student Assurance Services Inc.
P.O. Box 196
Stillwater, MN 55082
(800) 328-2739
www.sas-mn.com

The claim office is available for calls between 8:00 a.m. to 4:30 p.m. Central Time, Monday – Friday. You may check the status of a claim you have already filed at **www.saintxavierinsurance.com** and click on "Check Claims Online." You will need your member ID number located on your ID card to access the online claim status.

Saint Xavier University
2009-2010 STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN
Policy No. 12-64-0040-016-608-9

Insured _____

Underwritten by:
COLUMBIAN LIFE
INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196 • STILLWATER, MN 55082-0196

Current eligibility is subject to verification by the Servicing Agent.
$20 copay Physician Visits
$100 Emergency Room

Beech Street.
A CONCENTRA COMPANY

COMPLAINTS AND CLAIM APPEALS

Students and dependents have a right to file a Grievance in writing for any provision of services or claim practices of Columbian Life Insurance Company which offers a health benefit plan or its claim administration by Student Assurance Services, Inc.

If there is a problem or concern, the student or dependent can first call the customer service toll free number on the ID card. A customer service representative will assist in resolving the problem or concern as quickly as possible. If the student or dependent continues to disagree with the decision or explanation given, a written request may be submitted for a review though the internal grievance process.

You may initiate the internal grievance process by contacting Student Assurance Services, Inc. You have the right to:
- Submit written comments, documents, records, and other material relating to the review;
- Receive upon request, reasonable access to and copies of all documents relevant to your request for benefits relating to an Adverse Determination.

Your grievance will be reviewed and a determination will be mailed to you. You may obtain our Grievance Procedures by contacting Student Assurance Services, Inc. or from the Master Policy on file with your School.

Grievance may be sent to:
Student Assurance Services Inc.
P.O. Box 196 • Stillwater, MN 55082
(800) 328-2739

IMPORTANT! INSURANCE CARD (ID CARD)
1. You may detach and retain the temporary Identification Card provided in this brochure.
2. You MUST obtain your permanent Identification Card. The permanent identification card is necessary to check claim status online. Go to: **www.saintxavierinsurance.com** and click on "Print ID Card."
   The website will ask for your first and last name, your identification number, and your date of birth. Questions should be directed to (800) 452-5772.
3. You may call (800) 452-5772 and request that your Identification Card be mailed to you.

SERVICED BY:
Associated Insurance Plans International, Inc.
Phone: 800-452-5772
www.aipinternational.com

Direct All Claims and Correspondence to:
Student Assurance Services, Inc.
P.O.Box 196 • Stillwater, MN 55082-0196
- Written proof of loss must be furnished within 90 days after the date of such loss.
- The Master Policy prevails in the case of conflict.
- Precertification is not required.
- Providers: You may submit electronic claims to www.freeclaims.com; Payor ID: FCSAS.

PRIVACY NOTICE

We are committed to maintaining the privacy of your personal health information and complying with all state and federal privacy laws. You may obtain a copy of the Privacy Notice from the School, or by contacting Student Assurance Services, Inc. at 1-800-328-2739 or visiting website www.sas-mn.com.

OPTIONAL – ADDITIONAL PREMIUM REQUIRED
DENTAL/VISION/PHARMACY DISCOUNT PLAN

No Claim Forms
No Waiting Periods
No Pre-existing Conditions
No Deductible or Maximums
No Age Restriction
Discount is immediate at time of service
Over 100,000 participating providers nationwide

The Co-Health Group Collegiate plan has been specifically designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students attending the University.

The Co-Health Benefit Plan provides discounts in certain health care areas not normally reimbursed by insurance. In the "Collegiate Plan" we are offering the Vision, Dental and Pharmacy Discount Program as a singe package of Benefits, or you may purchase discounts for pharmacy or vision separately. Here's how the plan works.

This is not an Insurance Plan. The Co-Health Group Collegiate Plan is a Discount Care Plan offering discounts and savings for Vision, Dental and Prescription Pharmacy expenses.

Each of the benefit programs (Vision, Dental and Prescription Pharmacy) has a network of Providers (for example, the participating dentists in the Dental Plan). As a member of the Plan you can go to any of the providers listed and purchase their products or services on a negotiated discount basis. You receive your discount/savings on the spot. There are no exclusions for "pre-existing" conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership card at the time of your scheduled appointment or at a participating pharmacy.

The discounts you will receive are significant and these savings can be very important to you. The services that make up the Collegiate Plan (Vision, Dental and Pharmacy) are also the three most common areas where you will have unexpected expenses. With our Benefits, you can significantly reduce your out of pocket expenses, and as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington. You simply show your Co-Health ID Card and get your discount on the spot.

Annual Premiums – enroll anytime throughout the year at www.saintxavierinsurance.com. You do not need to purchase health insurance to enroll in the optional dental/ vision/pharmacy discount plan. For rate information call (800) 452-5772 or email at office@aipinternational.com.

Note: This program is not underwritten by Columbian Life Insurance Company.

SAINT XAVIER UNIVERSITY

2009-2010 GRADUATE STUDENT AND DEPENDENT ACCIDENT & SICKNESS INSURANCE ENROLLMENT FORM

☒ **COLUMBIAN LIFE INSURANCE COMPANY** • Home Office: Chicago, IL • Administrative Service Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381
❒ **COLUMBIAN MUTUAL LIFE INSURANCE COMPANY** • Home Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381

To apply for Student Accident and Sickness Insurance, either complete this enrollment form or enroll on-line at: www.saintxavierinsurance.com or mail to Associated Insurance Plans International, Inc. P.O. Box 189, Liberty, IL 60018.

Graduate Student ID: _____ Credit Hours _____

Student's Name _____ Soc. Sec. # ☐☐☐-☐☐-☐☐☐☐
(Please Print) (Last) (First) (MI)

22 Address _____
(Street) (City) (State) (Zip)

Birthdate _____ Telephone _____ email: _____
(MM/DD/YY)

*PREMIUM SCHEDULE (INDICATE PREMIUM SELECTED)

	Annual 08-11-2009 to 08-10-2010	**Fall Installment 08-11-2009 to 12-31-2009	**Spring/Summer Installment 01-01-2010 to 08-10-2010	***New Students Spring/Summer 01-01-2010 to 08-10-2010	Summer 05-19-2010 to 08-10-2010	****Monthly
Student	☐$ 1,216	☐$ 608	☐$ 608	☐$ 829	☐$ 329	☐$ 112
Additional for Spouse	☐$ 2,432	☐$ 1,216	☐$ 1,216	☐$ 1,621	☐$ 667	☐$ 213
Additional for Each Child	☐$ 1,824	☐$ 912	☐$ 912	☐$ 1,216	☐$ 503	☐$ 162

***** An administrative fee has been added to all student rates except Annual.
** The Fall and Spring/Summer Installment method of payment is only available for students purchasing Annual Coverage.
*** For new students not previously eligible to enroll for Annual or Fall insurance coverage.
23 ******** Monthly premium is available only if purchasing Annual coverage with an automatic debit from your checking, savings or credit card account. Complete the automatic debit authorization on the reverse side of this form.

Student and dependent coverage under the Policy becomes effective on the later of the following dates: the Policy Effective Date August 11, 2009 at 12:01 a.m.; the first day of the term for which the proper premium has been paid; or 12:01 a.m. following the date the proper premium is received by the Servicing Agent. Student and dependent coverage under the Policy will expire on the earliest of the following dates:The Policy Expiration date August 10, 2010 at 11:59 p.m.; or when payment for your Accident or Sickness coverage is due and unpaid. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master policy. This plan has an Enrollment Period, refer to the Brochure that accompanies this Enrollment Form.

DEPENDENT INFORMATION (COMPLETE IF PURCHASING DEPENDENT COVERAGE)

Spouse's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

☐ Enclosed is my check or money order, payable to Student Health Insurance, in the amount of $ _____.
Mail to: Associated Insurance Plans International, Inc. P.O. Box 189 Libertyville, IL 60048

☐ Please charge my credit card a one-time premium payment of $_____. Complete credit card information below.

☐ Please automatically charge my credit card the following Monthly premium for the entire policy year: $_____.
Complete the Automatic Payment Authorization Form on the reverse side of this form to activate this payment method.

Check credit card type: ☐VISA® ☐MasterCard® or ☐Discover®

Credit Card Number | Security Code (on back of card, 3 digits) | Card Expiration Date (Month) - (Year)

Credit card billing will state: "Student Health Insurance"

Cardholder Name/Cardholder Signature _____ Date ___/____/____
(Phone No.) (MM/DD/YY)

Cardholder Address _____
(Street) (City) (State) (Zip)

Student Signature _____ Date ___/____/____

AUTOMATIC PAYMENT WITHDRAWAL FORM (Credit Card, Checking or Savings Account)

☐ Please automatically charge my credit card the following monthly premium for the entire Policy Year $ _____.
Complete the credit card information and sign the Automatic Payment Authorization below to activate this payment method.

☐ Please automatically withdraw payment from my Checking or Savings account for the following Monthly premium for the entire policy year:
$_____ . Complete the bank account information and sign the Automatic Payment Authorization below to activate this payment method.

NOTE: Automatic payment from your checking account requires copy of a voided check; mail the voided check to Student Insurance Plan, Associated Insurance Plans International, Inc. P.O. Box 189, Libertyville, IL 60048.

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BANK ACCOUNT

Financial Institution: _____ Address: _____

Name of Bank Account Owner: _____ _____

Frequency: ( ) Monthly

Account Type: ( ) Checking or ( ) Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ must have 9 digits in routing #

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in account #

Attach a voided check, coded deposit slip if available

CREDIT CARD ACCOUNT

Check credit card type: ☐VISA® ☐MasterCard® or ☐Discover®

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Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Security Code (on back of card, 3 digits) ☐☐☐

Card Expiration Date (Month) (Year) ☐☐ - ☐☐

Cardholder Name/Cardholder Signature _____ Date ___/____/____
(Phone No.) (MM/DD/YY)

Cardholder Address _____
(Street) (City) (State) (Zip)

Automatic Payment Authorization

I authorize the payment of debits drawn on my checking, savings, or credit card account payable to Columbian Life Insurance Company and/or its designee ("the Company"), provided there are sufficient funds in the account. I agree that the Company shall be under no liability whatsoever in the event of one or more dishonored debits, whether any alleged harm or damage is directly or indirectly the result of the dishonor, and whether the dishonor results in the forfeiture of insurance or any other harm or damage.

I hereby waive any requirement for giving notice of premiums due as long as this Authorization is in effect. No premium shall be deemed to have been paid until the Company receives the actual payment which is not subsequently reversed. The use of this Plan shall in no way change the provisions of the policy with respect to the termination of such Policy upon nonpayment of the premium due.

This Authorization shall remain in effect until August 11, 2010, or until terminated by me upon a thirty day written notice to the Company. The Company may terminate the Automatic payment plan if any banking or credit card fund transfer is not paid on presentation. Upon termination, premiums due under the Policy shall be payable directly to the Company.

For Monthly premiums, your account will be debited on the 11th of each month through July 11, 2010.

_____ _____

Authorized Signature as it appears on Bank Records or Credit Card Date

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