

# *Critical Illness Insurance*

## *A Specified Disease Policy*



FIELD REFERENCE GUIDE

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# Underwriting Rules

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## Introduction

Your importance in the underwriting process cannot be overemphasized. The job you do affects your client's feeling toward you and the Companies, and it can affect the availability of this type of insurance at an affordable price.

## Issue Ages

Ages 20 through 59

## Individual Critical Illness State Availability

Individual Critical Illness is available in all states except:

- Connecticut
- Louisiana
- Maryland
- Massachusetts
- New Hampshire
- New Jersey

## Couples

If	Then use policy form	With the annual policy fee of
Both husband and wife are issued,	CI3 (one policy per person)	\$25 per policy
One spouse is issued,	CI2	\$50

## Underwriting

An Underwriting interview will be completed on each application.

## Underwriting Outcomes

Critical Illness insurance is fully underwritten and issued as:

- Standard;
- Substandard with rate-up (25%, 50%, 75% or 100%); or
- Declined (**No Eliminations**).

## Attending Physician Statement

Generally, Attending Physician's Statements will be ordered more often with critical illness applications. Some conditions which may require an APS are recent doctor visits, circulatory disorders (high blood pressure) and growth removal (polyps and moles).

Attending Physician's Statement (APS) requirements:

- If the proposed insured has not seen a doctor within the last 2 years and:
  - (a) Is age 50 or older and/or
  - (b) Is applying for a benefit of \$250,000 or greater

then the proposed insured must have a complete physical exam by an M.D. at the proposed insured's expense.

# Underwriting Rules, Continued

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## Benefit Amounts

Benefits are purchased:

- In increments of \$1,000
- With a \$25,000 minimum benefit.

## Financial Guidelines

Benefit amounts should generally be within 3 to 5 times annual income plus outstanding mortgage balance.

Financial requirements for benefits of \$250,000 and above:

- For self-employed individuals: 2 years proof of income including complete tax returns
- For salaried individuals: the most recent W2 or pay stub showing one full month with year-to-date earnings
- For all individuals: cover letter to justify benefit amount
  - include how the requested benefit amount was derived (example—three times annual salary plus mortgage balance)
- Underwriters may request these additional requirements for amounts less than \$250,000 if needed to qualify the risk

For business situations, such as buy-sell, key person or credit protection, please provide a cover letter outlining the basis for determination of the benefit amount.

In New York, the maximum benefit amount available is \$500,000, subject to the Risk Class Guidelines.

## New York Risk Class Guidelines

Risk Class	Maximum Benefit Amount Available
Standard and +25	\$500,000
+50	\$250,000
+75	\$100,000
+100	\$50,000
+150	Not available

## Application

Use the currently approved Critical Illness application.

## Modes

The premium modes for Critical Illness insurance are the following:

- Annual
- Semiannual
- Quarterly
- Bank Service Plan (BSP)
- Payroll Deduction (PRD)

Regular monthly mode is NOT available.

## Issue Requirements

Persons in New York may only have one specified disease policy (Critical Illness) with this or any other company.

# Underwriting Rules, Continued

## Issue Exceptions

CI2/CI3 may not be issued to persons on Medicare or Medicaid.

## Foreign Nationals

CI2/CI3 may not be issued to Foreign nationals living in the U.S. for less than 3 years. (To be eligible, these individuals must have 3 years of uninterrupted residency in the U.S. Proof of alien status will be required (i.e., Alien Registration number and inspection of Registration Receipt Card – green card).

## Guidelines when Considering Immigrants and Non-Immigrants for Insurance Coverage (M24221)

Acceptable Immigrant Status for Consideration and/or Health Insurance Coverage. An individual with a valid Alien Registration Receipt Card (also known in layman’s term as a “Green Card”) will be eligible to apply for such coverage. In addition, the individual must meet all four requirements listed below:

1. Reside in the United States for a minimum of 12 consecutive months to apply for life insurance coverage and 36 consecutive months to apply for health insurance coverage.
2. Have a minimum net annual income of \$20,000 from U.S. based assets or entitlement benefits (i.e., social security or pension benefits) or U.S. based employment.
3. Show intent to reside permanently in the United States. Some examples of this intent are:
  - Own a home in the United States,
  - Own business in the United States, and/or,
  - Have child or children who are United States citizens and who reside in the United States.
4. Complete the Foreign National Questionnaire (L5719\_1103).

**Unacceptable Non-Immigrant Visas.** Except as otherwise noted below, individuals who have the following temporary visas WILL NOT be considered for life and/or health insurance coverage:

A-1	D-2	H-1C	L-2*	P-4
A-2	E1	H-2A	M-1	Q-1
A-3	E2	H-2B*	M-2	Q-3
B-1	F1	H-3	N-8	R-1
B-2	F2	H-4	N-9	R-2
C-1	G1	J-1	O-1	S-5
C-1D	G2	J-2	O-2	S-6
C-2	G3	K-1	O-3	
C-3	G4	K-2	P-1	
C-4	G5	L-1A*	P-2	
D-1	H-1B*	L-1B*	P-3	

We will also not consider individuals who reside in the United State because of their receipt of a Political Asylum or Humanitarian Asylum Visa.

**Note:** Some individuals who have a valid H-1B, H-2B, L-1A, L-1B, or L-2 visa may be considered for life and/or health insurance coverage. The producer must contact Life Underwriting and/or Health Underwriting, as applicable, to discuss the case and obtain the applicable underwriting approval before completing an application.

## Active Military

CI2/CI3 may be issued to active Military officers and non-commissioned officers (Sergeant E-5 and above) only.

# Underwriting Rules, Continued

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## Verification of Other Health Coverage

The following process will be followed for verifying other health coverage:

- (1) A licensed agent completes the application and a telephone interview with an underwriter is arranged.
- (2) The Critical Illness application is received at Mutual of Omaha Insurance Company.
- (3) The application is forwarded to the Underwriting area for handling.
- (4) An underwriter will check to see if the major medical or basic hospital and basic medical coverage question has been answered as “yes” or “no”.
- (5) If the question is answered “yes”, the application will be processed.
- (6) If the question is answered “no”, the application will be rejected.
- (7) If the question is unanswered, the agent will be requested to secure a statement signed by the applicant answering the question, which will then be returned to the Mutual of Omaha’s Underwriting area for further processing.
- (8) The policy issue package will include a letter verifying the fact that the customer still has major medical or basic hospital and basic medical coverage.
- (9) The policy will be issued and must be delivered to the customer within 30 days of issue.
- (10) In regard to the letter contained in the issue package, the customer will be requested to check “Yes” they do have major medical or basic hospital and basic medical coverage in force as of the issue date or “No” they do not. The insured will then sign this letter and give to the agent/broker at the time the policy was delivered. The agent/broker will be required to return this signed letter to the Home Office.
- (11) If the insured no longer has major medical or basic hospital and basic medical coverage in force, the policy will be void and the premium will be returned.
- (12) If the required letter is not received by underwriting within 60 days of the policy issue date, the policy will be voided and the premium will be returned to the applicant.

## Consideration Guide

The following list of medical conditions can be utilized to help you determine the insurability of your clients. Conditions not listed, multiple medical conditions, or the use of multiple medications will be evaluated by our Underwriting Department to determine insurability.

### Asthma

Mild .....	Standard
Moderate .....	+75
Severe .....	Decline

### Atrial Fibrillation

Paroxymal	
No cause found and no underlying cardiac disease .....	+100
If under treatment with anticoagulation .....	+75
Chronic or recurrent	
No cause found and no underlying cardiac disease, on anticoagulation therapy and no cardiac impairment .....	+75
If on anticoagulation therapy or cardiac impairment present .....	Decline

### Benign Breast Disorders

- Fibrocystic disease diagnosed within 2 years and no biopsy performed or pending.....+50
- Breast disorders that include a biopsy (pathology report required) ..... Insurability and rating based upon pathology report

# Underwriting Rules, Continued

## Cholesterol

Ages 0-49 years

CHOLESTEROL/HDL RATIO					
TOTAL CHOLESTEROL	<5.7	5.7-7.1	7.2-8.6	8.7-10.0	>10.0
<200	+0	+0	+50	+75	+100
200-240	+0	+0	+75	+100	Decline
241-300	+0	+50	+100	+100	Decline
301-350	+25	+75	+100	Decline	Decline
351-400	+50	+100	Decline	Decline	Decline
>400	Decline	Decline	Decline	Decline	Decline

Ages 50 and over

CHOLESTEROL/HDL RATIO					
TOTAL CHOLESTEROL	<5.7	5.7-7.1	7.2-8.6	8.7-10.0	>10.0
<200	+0	+0	+25	+50	+75
200-240	+0	+0	+50	+75	+100
241-300	+0	+0	+75	+100	Decline
301-350	+0	+50	+100	Decline	Decline
351-400	+25	+75	+100	Decline	Decline
>400	Refer to MD	Refer to MD	Decline	Decline	Decline

If cholesterol/HDL ratio is not available, then rate the cholesterol alone as follows:

Ages 0-49 years

Total Cholesterol	<250.....+0
	251-300.....+50
	301-350.....+100
	351-400.....+150

Ages 50 and over

Total Cholesterol	<250.....+0
	251-300.....+25
	301-350.....+75
	351-400.....+100

TRIGLYCERIDES (12 HOUR FASTING SAMPLE)

<400.....+0
401-800.....+50
>800.....Refer to MD

## Diabetes Mellitus

**Type I:** Formerly called juvenile onset (JODM) or insulin-dependent diabetes mellitus (IDDM) .....Decline

**Type II:** Formerly called adult onset (AODM) or non-insulin dependent diabetes mellitus (NIDDM). Consider only those candidates with good blood sugar control, i.e., HBA1C under 8%, no microalbuminuria, no complications (including neuropathy, peripheral vascular disease, renal impairments, or retinopathy or diabetic coma) and no debits for build (over +50%) blood pressure, or lipids.

## Underwriting Rules, Continued

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**Must have current HBA1C and Microalbumin readings.**

**Age at diagnosis:**

Under age 45 .....	Decline
Age 46-54.....	+100
Age 55 and up .....	+75/+50

**Gestational Diabetes:** Can consider 3 months post partum.

Normal blood profile.....	Standard
Abnormal .....	Rate for findings

### **Papanicolaou (PAP) or Cervical Smears**

Screening Test: Papanicolaou (PAP) Smear

- Class I (normal).....Standard
- Class II (atypical) .....Standard
- Class III (dysplasia) .....Postpone\*
- Class IV (carcinoma in situ) .....Decline
- Class V (invasive carcinoma) .....Decline

*\*With treatment and resolution of abnormality, confirmed with normal (Class I) PAP results, allow Standard.*

### **Polyps**

Certain types of non-malignant colon and small intestine polyps may be standard.

# Uninsurable Conditions

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## Overview

Because of the nature of Critical Illness insurance, certain medical conditions will cause an individual to be ineligible for coverage.

## Uninsurable Conditions

If a person has or ever has had any of the following medical conditions, he or she is **NOT** eligible for Critical Illness coverage. This list is NOT all inclusive, but does include many of the unacceptable health conditions you may encounter:

1. AIDS, HIV+
2. Alcohol or Drug Abuse (currently or treatment within 5 years)
3. Alzheimer's Disease
4. Angina
5. Angioplasty
6. Cancer (does not include most skin cancers)
7. Cardiomyopathy
8. Chronic Kidney Disease
9. Congestive Heart Failure
10. Coronary Artery Bypass
11. Cystic Fibrosis
12. Heart Attack
13. Hepatitis C
14. Huntington's Chorea
15. Insulin Dependent or Uncontrolled Diabetes
16. Kidney Failure
17. Major Organ Transplant
18. Multiple Sclerosis
19. Muscular Dystrophy
20. Permanent Paralysis
21. Polycystic Kidney Disease
22. Stroke
23. Systemic Lupus Erythematosus

# Family History Guidelines

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## Overview

Family history can affect an applicant’s eligibility or rating for Critical Illness coverage. Use the following information as guidelines in qualifying an applicant with a significant family history.

NOTE: The following examples represent the most frequent family history scenarios. The table is not intended to represent the only situations where underwriting action would be taken due to family history.

## Family History

Family history can affect an applicant’s eligibility or rating for critical illness coverage and is a more significant risk factor than with respect to life insurance. Family history includes notable health history on any first-degree relative (defined as a natural parent or a natural brother or sister). It doesn’t include grandparents, aunts, uncles, stepparents or stepbrothers or stepsisters.

Conditions such as heart disease, stroke, high cholesterol and diabetes demonstrate a genetic disposition. Certain types of cancer have a strong genetic tendency. For example, someone with a family member that has had breast, ovarian and colon cancer has an increased risk of developing those types of cancer. Generally, the younger the family member was diagnosed the more the risk increases.

Asking the family history question – “Have you or any first degree relative been diagnosed with cancer, heart disease or diabetes before age 60?” – is critical while completing the application with your client. Unless two or more first-degree relatives have been diagnosed prior to age 60, family history isn’t an issue and there will be no rating. The exception will be breast and colon cancer, when there could be a rating if one first degree relative was diagnosed with colon or breast cancer prior to age 60.

Family history may be taken into consideration with other factors such as obesity, high blood pressure, high cholesterol and smoking.

### Cancer – Consider All Malignant Tumors Diagnosed in Any Family Member Prior to Age 60

#### Single Family Member with History of Cancer

Malignant Tumors other than Breast or Colon.....Standard

#### Multiple Family Members with History of Cancer

Malignant Tumors other than Breast or Colon, diagnosed in different locations:

Two family members .....+50\*

Three family members.....Decline

Four family members .....Decline

\*Credit – 25% if applicant is over age 50

Malignant Tumors other than Breast or Colon, same location:

Two family members .....+100\*

Three or more family members .....IC, Usually Decline

\*Credit – 25% if applicant is over age 50

Malignant Tumors **including** one Breast or Colon, diagnosed in different locations

Two family members .....+100

Three or more family members .....Decline

# Family History Guidelines, Continued

## Breast Cancer (in immediate family members before age 60)

Note: if genetic tests are available .....Refer to MD

### Female applicants

One family member:

Applicant under age 50

Onset in family member under age 50 .....+50

Onset in family member between ages 50-60.....+25

Applicant over age 50

Onset in family member under age 50 .....+25

Onset in family member between ages 50-60.....Standard

Two family members:

Applicant under age 50

Onset in both family members under age 50 .....Decline

Onset in one family member under age 50 and the other between 50-60 .....+100

Onset in both family members between ages 50-60 .....+75

Applicant over age 50

Onset in both family members under age 50 .....+100

Onset in one family member under age 50 and the other between 50-60 .....+75

Onset in both family members between ages 50-60 .....+50

Three or more family members.....Decline

### Male applicants

Two or more females with breast cancer in immediate family.....+25

## Colorectal Cancer (excluding Familial Adenomatous Polyposis and HNPCC)

Diagnosed in immediate family member before age 60

One family member .....+50

Two family members .....+100

Three or more family members.....Decline

## Familial Adenomatous Polyposis (FAP)

A rare disease inherited autosomal dominantly which can be genetically screened for. It is characterized by a large number of adenomatous tumors arising from the mucous lining of the colon and rectum, which inevitably undergo malignant change.

**Congenital hypertrophy of the retinal pigment epithelium (CHRPE)** is present in two thirds of those suffering with FAP and is useful for screening purposes in young patients.

### Definite diagnosis in immediate family member

No genetic test performed.

Normal colonoscopy and no history of polyps,

No hypertrophy of retinal pigment epithelium,

Age 40 and under .....Decline

Over age 40 .....Standard

## Family History Guidelines, Continued

### Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

The clinical criteria for hereditary nonpolyposis colorectal cancer (HNPCC) include 3 or more first degree relatives (spanning at least 2 generations) with colon cancer, with one or more cases diagnosed before age 50. The colon cancers associated with this syndrome often occur on the right side of the colon, and women with this syndrome also have increased risk of ovarian and endometrial cancers.

All Applicants.....Decline

### Cardiovascular, Cerebrovascular (in immediate family members before age 60)

Immediate family members are considered to be parents and siblings, both male and female lives.

One family member:.....Standard

#### Two family members:

Applicant under age 50

Onset in both family members under age 50.....Decline

Onset in one family member under age 50 and the other member 50-60 .....+100

Onset in both family members between 50-60.....+75

Applicant over age 50\*

Onset in both family members under age 50.....+100

Onset in one family member under age 50 and the other member 50-60 .....+75

Onset in both family members between 50-60.....+50

Three or more family members:.....IC, Usually Decline

\*Consider a credit of 25% in non-smoking applicants over age 50 with normal lipids, blood pressure, no build debits, and normal ECG if available.

### Diabetes

Diagnosis in immediate family member before age 60

One immediate family member .....Standard

Two or more immediate family members\*

Both NIDDM.....+50

One NIDDM and one IDDM .....+75

Both IDDM .....+100

\*Credit 25% for applicants over age 50 with normal blood profile, build, BP, lipids, and no adverse health history.

### **Substandard Ratings**

The Critical Illness underwriter will determine any final, substandard rating by using the:

- Application;
- Interview; and
- Other requirements needed

Address any specific questions to the Underwriting Department.

# Build Chart

Use the following table in the underwriting process to determine standard and substandard rates or decline for Critical Illness insurance coverage.

Height Feet and Inches	Height Inches	Decline Below	Weight Range to be Considered as:					Decline Over
			Standard	+25%	+50%	+75%	+100%	
4'8"	56"	80	80 - 129	130 - 138	139 - 151	152 - 160	161 - 173	174+
4'9"	57"	83	83 - 134	135 - 143	144 - 157	158 - 166	167 - 180	181+
4'10"	58"	86	86 - 138	139 - 148	149 - 162	163 - 172	173 - 186	187+
4'11"	59"	89	89 - 143	144 - 153	154 - 168	169 - 178	179 - 193	194+
5'0"	60"	92	92 - 148	149 - 158	159 - 174	175 - 184	185 - 199	200+
5'1"	61"	95	95 - 153	154 - 164	165 - 179	180 - 190	191 - 206	207+
5'2"	62"	98	98 - 158	159 - 169	170 - 185	186 - 196	197 - 213	214+
5'3"	63"	102	102 - 163	164 - 175	176 - 191	192 - 203	204 - 220	221+
5'4"	64"	105	105 - 168	169 - 180	181 - 198	199 - 209	210 - 227	228+
5'5"	65"	108	108 - 174	175 - 186	187 - 204	205 - 216	217 - 234	235+
5'6"	66"	112	112 - 179	180 - 192	193 - 210	211 - 223	224 - 241	242+
5'7"	67"	115	115 - 185	186 - 197	198 - 217	218 - 229	230 - 249	250+
5'8"	68"	118	118 - 190	191 - 203	204 - 223	224 - 236	237 - 256	257+
5'9"	69"	122	122 - 196	197 - 209	210 - 230	231 - 243	244 - 264	265+
5'10"	70"	125	125 - 202	203 - 216	217 - 236	237 - 250	251 - 271	272+
5'11"	71"	129	129 - 207	208 - 222	223 - 243	244 - 258	259 - 279	280+
6'0"	72"	133	133 - 213	214 - 228	229 - 250	251 - 265	266 - 287	288+
6'1"	73"	136	136 - 219	220 - 234	235 - 257	258 - 272	273 - 295	296+
6'2"	74"	140	140 - 225	226 - 241	242 - 264	265 - 280	281 - 303	304+
6'3"	75"	144	144 - 232	233 - 248	249 - 272	273 - 288	289 - 312	313+
6'4"	76"	148	148 - 238	239 - 254	255 - 279	280 - 295	296 - 320	321+
6'5"	77"	152	152 - 244	245 - 261	262 - 286	287 - 303	304 - 328	329+
6'6"	78"	156	156 - 250	251 - 268	269 - 294	295 - 311	312 - 337	338+
6'7"	79"	160	160 - 257	258 - 275	276 - 301	302 - 319	320 - 346	347+
6'8"	80"	164	164 - 264	265 - 282	283 - 309	310 - 327	328 - 355	356+
6'9"	81"	168	168 - 270	271 - 289	290 - 317	318 - 335	336 - 363	364+
6'10"	82"	172	172 - 277	278 - 296	297 - 325	326 - 344	345 - 373	374+
6'11"	83"	176	176 - 284	285 - 303	304 - 333	334 - 352	353 - 382	383+

Build rate-ups may be influenced by other health factors such as High Blood Pressure. Applicants with combinations of High Blood Pressure and overweight may be subject to a higher rate-up. However, applicants with well controlled blood pressure that do not have any other impairments may be rated standard.

## Occupations

### C12/C13

Most occupations will be considered standard for the Critical Illness product. The following occupations, however, are examples of "risky" occupations and would normally be ineligible for Critical Illness coverage:

- Asbestos Workers
- Underground Miners
- Commercial Divers

# Underwriting Requirements

## Underwriting Process

Use the underwriting process with the individual Critical Illness product. Follow these steps:

- Complete the application;
- Collect the premium amount (at least 2 months BSP);
- Determine and execute the necessary testing procedures (oral fluid, blood & urine, paramed, etc.); and
- Call a Client Interviewer through the PAL line for completion of an interview.

Indicate all the initiated or completed underwriting requirements on the submission checklist.

## Underwriting Requirements

The following table provides valuable information on the procedures required for applicants according to both age and coverage amount:

Age	Through \$99,000	\$100,000 through \$199,000	\$200,000 through \$500,000
20-39	Interview Oral Fluid	Interview *Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine MVR
40-49	Interview Oral Fluid	Interview Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine MVR
50-59	Interview Oral Fluid	Interview Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine MVR

\*This requirement may be waived if medical records are available within 12 months of an M.D. visit which included a blood and urinalysis and physical data. These cases should include a current oral fluid.

**Interview** – A complete detailed underwriting phone interview

**Oral Fluid** – Agent collected oral fluid test

**Blood & Urine** – A blood and urine collection by an approved paramedical vendor

**Paramed** – A long form paramedical exam (form MLU21727-30)

**M.D. Exam** – M.D. completed paramedical exam (specializing in internal medicine) on form MLU21727-30

**EKG** – Electrocardiogram

**TEKG** – Treadmill Electrocardiogram

**MVR** – Motor Vehicle Report

# Client Interview Process

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A personalized underwriting process designed to recognize that no two of our clients are the same. The agent thoroughly prepares the client for a one-on-one dialogue with the underwriter, and the pertinent health information is gathered.

## **For Best Results**

1. Complete and sign the application.
2. Review “[The Importance of an Accurate Health History](#)” with the client.
3. Orient the client with the client profile interview. Advise the client that the interview will be recorded. Displaying confidence in the process will reduce the client’s concerns.
4. Have the client gather his or her doctor and medication information.
5. If needed, collect the oral fluid – a critical piece of the client profile. (See instructions)
6. Make the phone call – greet the client interviewer in a warm, friendly manner.
7. Turn the phone over to the client to begin the client profile interview. Allow the client complete privacy during the interview.

## **Completing a Client Profile**

Call PAL **1-800-775-3000** and choose client profile option (press 1).

Hours: 9:00 a.m. – 9:00 p.m. EST Monday – Thursday

9:00 a.m. – 6:00 p.m. EST Friday

## **Oral Fluid Collection**

### ***Pre-Collection Process***

Review the oral fluid collection process with the client. Complete the authorization form.

### ***Collection Process***

Open the outer package revealing the plastic handle of the collection pad. Offer the collection pad, handle end first, to the client.

Insert the collection pad into the mouth, between the lower cheek and gum, and leave in the mouth for two to five minutes.

Prepare the vial by printing the client’s name and date on the vial label; remove the cap from the vial.

Place the collection pad in the vial, making sure to push the collection pad down into the blue liquid. Break off the upper half of the collection pad plastic handle and discard.

Snap the cap back on the vial.

Sign, date and initial the Tamper Evident Tape.

Place the Tamper Evident Tape over the vial cap.

### ***Post-Collection Process***

Read, sign and date the “Notice, Consent and Chain of Custody” statements on the authorization form.

Print name and sign “Collection Verification” section on the authorization form and give the client a copy. Place sealed vial and lab copies of authorization form in the envelope. Drop in a U.S. post office box.

## **For Best Results**

After eating, drinking or smoking, the client should wait at least five minutes before collecting an oral fluid.

Watch the time – having the collection pad in the mouth for less than two minutes will distort the results.

# Glossary

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## Alzheimer's Disease

### Policy Definition

Alzheimer's Disease means the Diagnosis of Alzheimer's Disease by a Physician who is a certified neurologist or other provider whose license permits him or her to make such a diagnosis. Alzheimer's Disease is a progressive degenerative disease of the brain. The Diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment, which results in a significant reduction in mental and social functioning, such that the Insured requires permanent daily personal supervision and is unable to perform independently one or more of the following activities of daily living: transferring (moving in or out of bed or chair), dressing, bathing, feeding and toileting. All other dementing organic brain disorders and psychiatric illnesses are excluded from this Insured Condition.

### Practical Interpretation

Alzheimer's Disease is a progressive degenerative brain disease characterized by memory loss and loss of judgment resulting in a significant reduction in mental and social functions. To receive policy benefits, the insured must require permanent daily supervision and be unable to perform three or more activities of daily living.

### Critical Illness Insurance Plan Pays

for Alzheimer's Disease when a neurologist diagnoses the insured with the advanced stage of Alzheimer's in which he/she:

- requires permanent daily supervision; and
- cannot do one or more of these activities of daily living without help:
  - (1) move in or out of a bed or chair (transferring)
  - (2) dress
  - (3) bathe
  - (4) feed
  - (5) use the toilet

## **Carcinoma in Situ**

### **Policy Definition**

Carcinoma in Situ means the Diagnosis of cancer wherein the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. Carcinoma in Situ includes early prostate cancer diagnosed as TIN0M0 or equivalent staging, but does not include skin cancer. Carcinoma in Situ must be Diagnosed pursuant to a Pathological Diagnosis or Clinical Diagnosis.

### **Practical Interpretation**

Carcinoma in Situ is a condition in which malignant cells have the potential to invade and metastasize, but have not done so yet.

Exception:

- skin cancer

Limitation:

Carcinoma in Situ is not covered if, within 30 days following the policy issue date or the last reinstatement date, the insured:

- is Diagnosed with Carcinoma in Situ.

### **Critical Illness Insurance Plan Pays**

For Carcinoma in Situ when the insured's cancer tumor is:

- malignant;
- located only in its original part of the body (has not spread); and
- pathologically or clinically diagnosed (see Diagnosis).

## Life-Threatening Cancer

### Policy Definition

Life-Threatening Cancer means a malignant neoplasm (including hematologic malignancy), that is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are not considered a Life-Threatening Cancer: early prostate cancer diagnosed as T1N0M0 or equivalent staging; Carcinoma in Situ; pre-malignant lesions (such as intraepithelial neoplasia), benign tumors or polyps; any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life-Threatening Cancers. Life-Threatening Cancer must be diagnosed pursuant to a Pathological Diagnosis or a Clinical Diagnosis.

### Practical Interpretation

Life-Threatening Cancer is an uncontrolled growth of abnormal cells that invade healthy tissue. These growths are called malignant tumors and if untreated, can interfere with normal body functions and ultimately cause death.

Life-Threatening Cancer normally includes but is not limited to these cancers:

- (1) lung
- (2) breast
- (3) colon
- (4) leukemia, lymphoma
- (5) prostate (except as described below)
- (6) bone
- (7) kidney
- (8) bladder
- (9) invasive malignant skin cancer (melanoma in the dermis or deeper) and
- (10) skin malignancies that have become life threatening.

Exceptions:

- (1) early prostate cancer diagnosed as a tumor (T1N0M0) or equivalent staging
- (2) Carcinoma in Situ
- (3) Pre-malignant lesions, benign or pre-malignant tumors, or polyps, and
- (4) Any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life-Threatening Cancers.

Limitation:

Life-Threatening Cancer is not covered if, within 30 days following the policy issue date or the last reinstatement date, the insured:

- is Diagnosed with Life-Threatening Cancer.

### Critical Illness Insurance Plan Pays

For Life-Threatening Cancer when the insured's cancer is:

- Malignant;
- Growing uncontrollably outside its original area; and
- Pathologically or clinically diagnosed (see Diagnosis).

## **Skin Cancer**

### **Policy Definition**

Skin Cancer means a skin malignancy that is not considered Life Threatening Cancer or is not classified as Carcinoma in Situ. Skin Cancer must be Diagnosed pursuant to a Pathological Diagnosis or Clinical Diagnosis.

### **Practical Interpretation**

Skin cancer is a malignancy of the skin, which is not considered life threatening or Carcinoma in Situ. Common skin cancers are Basal Cell and Squamous Cell cancers.

Limitation:

Skin Cancer is not covered if, within 30 days following the policy issue date or the last reinstatement date, the insured:

- is Diagnosed with Skin Cancer.

### **Critical Illness Insurance Plan Pays**

A malignant (cancerous) lesion on the skin (not considered life threatening or in situ) is diagnosed pathologically or clinically.

## **Coronary Atherosclerotic Heart Disease**

### **Policy Definition**

“Coronary Atherosclerotic Heart Disease” means the diagnosis of at least 75% cross-sectional occlusion of one or more major coronary arteries (Left Main, Left Anterior Descending, Circumflex or Right Coronary Artery) as a result of Coronary Atherosclerotic Heart Disease. The diagnosis must be confirmed by coronary arteriography or other recognized diagnostic techniques capable of assessing precisely the degree of arterial stenosis.

### **Practical Interpretation**

Blockage of the coronary arteries indicates Coronary Atherosclerotic Heart Disease. This blockage is considered significant if 75% or more of one or more of the major arteries is obstructed. The blockage may cause reduced blood flow to the heart, which may result in a heart attack or symptoms of angina (chest pain). Depending on the clinical situation, angioplasty or bypass surgery may be required for treatment. This must be confirmed by arteriography or other recognized diagnostic techniques.

### **Critical Illness Insurance Plan Pays**

When at least 75% of one of the major coronary arteries is blocked and diagnosed through arteriography.

## **Heart Attack (Myocardial Infarction)**

### **Policy Definition**

Heart Attack (Myocardial Infarction) means the death of a portion of the heart, resulting from blockage of one or more coronary arteries. In order to be covered under this policy, the Diagnosis of Heart Attack (Myocardial Infarction) must be based upon both:

- (1) new electrocardiographic changes consistent with and supporting a Diagnosis of Heart Attack (Myocardial Infarction); and
- (2) a concurrent diagnostic elevation of cardiac enzymes; or
- (3) other appropriate means customarily used in the medical community consistent with Heart Attack.

### **Practical Interpretation**

A heart attack occurs when the blood supply to a portion of the heart's muscle is blocked resulting in permanent tissue death and scarring. The Diagnosis is based upon new changes on the electrocardiographic (ECG or EKG) and affirmative blood tests.

### **Critical Illness Insurance Plan Pays**

For a Heart Attack (Myocardial Infarction) when the insured's:

- heart's blood supply is blocked
- heart has permanent tissue death and scarring, and
- diagnosis is based on new changes on the electrocardiogram (ECG or EKG) and blood tests.

## Major Organ Transplant

### Policy Definition

Major Organ Transplant means clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the insured to be replaced with the organ(s) or tissue from a suitable donor under generally accepted medical procedures. Those organs or tissues covered by this definition are liver, kidney, lung, entire heart, small intestine, pancreas, or bone marrow. In order for the Insured's Major Organ Transplant to be covered under this policy, the Insured must also be registered by the United Network of Organ Sharing (UNOS).

### Practical Interpretation

A Major Organ Transplant is a surgical procedure to replace the recipient's malfunctioning organ(s) or tissue with an organ(s) or tissue from a suitable donor. The insured must be registered by the United Network of Organ Sharing.

The following organs or tissues are covered:

- liver
- kidney
- lung
- entire heart
- small intestine
- pancreas
- bone marrow

### Critical Illness Insurance Plan Pays

For Major Organ Transplant when:

- there is clinical evidence a major organ has failed;
- the insured's malfunctioning organ(s) or tissue must be replaced with a suitable donor's organ(s) or tissue; and
- the insured is registered with the United Network of Organ Sharing.

## **Multiple Sclerosis**

### **Policy Definition**

Multiple Sclerosis means a definitive diagnosis of Multiple Sclerosis by a Physician who is a certified neurologist or other provider whose license permits him or her to make such a diagnosis. The Diagnosis must be based on at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions at more than one site within the central nervous system, and must also be supported by modern investigative techniques.

### **Practical Interpretation**

MS is a condition of the nervous system that is commonly progressive and results in multiple and varied nervous symptoms. These may be intermittent and follow a course that alternates from very active to non-existent. A neurologist's diagnosis is based upon abnormal symptoms and physical exam findings. Modern X-ray imaging may also be used to confirm the diagnostic impression.

Neurological symptoms include:

- numbness and tingling in the hand or arm;
- loss of vision in one eye;
- weakness in the leg with difficulty walking; and
- double vision.

### **Critical Illness Insurance Plan Pays**

For Multiple Sclerosis when the insured has:

- at least two episodes of abnormal neurological symptoms; and
- lesions in more than one place in the central nervous system.

## Stroke

### Policy Definition

Stroke means a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 30 days following the occurrence of the Stroke. Stroke does not include Transient Ischemic Attack (TIA).

### Practical Interpretation

Stroke affects the blood vessels supplying blood to the brain. It is also sometimes called “brain attack.” A stroke occurs when a blood vessel bringing oxygen and nutrients to the brain bursts or is clogged by a blood clot or some other particle. Because of this rupture or blockage, part of the brain doesn’t get the flow of blood it needs. A warning sign of a potential stroke, TIA is not covered by Critical Illness insurance.

Exceptions:

- Transient Ischemic Attack (TIA).

### Critical Illness Insurance Plan Pays

For Stroke when:

- a blood vessel ruptures in the brain; or
- a blood clot blocks blood flow through the brain; and
- the neurological injury lasts for at least 30 days.

## Date of Diagnosis

### Policy Definition

Date of Diagnosis means the date the Diagnosis is established after the Policy Issue Date, by a Legally Qualified Physician acting within the scope of his or her license, through the use of clinical findings or other appropriate means customarily used in the medical community for the illness diagnosed as supported by the Insured’s medical records.

### Practical Interpretation

The date a Legally Qualified Physician acting within the scope of his or her license confirms through clinical tests or other appropriate means customarily used in the medical community for the illness diagnosed that the insured has a Critical Illness condition.

## Diagnosis

### Policy Definition

Diagnosis means the definitive establishment of the Insured Condition through the use of clinical findings or other appropriate means customarily used in the medical community for the illness diagnosed after the Policy Issue Date. The Diagnosis must be made by a Legally Qualified Physician who is acting within the scope of his or her license.

### Practical Interpretation

A Legally Qualified Physician uses clinical test or other appropriate means customarily used in the medical community for the illness diagnosed to conclude that the insured has a Critical Illness condition.

## Clinical Diagnosis

### Policy Definition

Clinical Diagnosis means a Diagnosis of Life-Threatening Cancer, Carcinoma in Situ or Skin Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Life-Threatening Cancer, Carcinoma in Situ or Skin Cancer only if the following conditions are met:

- (a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening.
- (b) there is medical evidence to support the Diagnosis, and
- (c) a Legally Qualified Physician is treating the Insured for Life-Threatening Cancer, Carcinoma in Situ or Skin Cancer.

### Practical Interpretation

Type of Diagnosis	Conditions
Clinical	<ul style="list-style-type: none"><li>■ a physician who is treating the insured for cancer studies symptoms and diagnostic test results;</li><li>■ a Pathological Diagnosis is medically inappropriate or life threatening; and</li><li>■ medical evidence supports the diagnosis.</li></ul>

## Pathological Diagnosis

### Policy Definition

Pathological Diagnosis means a Diagnosis of Life Threatening Cancer, Carcinoma in Situ or Skin Cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Legally Qualified Physician who is also a board certified pathologist and whose Diagnosis of malignancy conforms with the standards set by the American College of Pathology.

Clinical or other medically appropriate Diagnosis of Life Threatening Cancer, Carcinoma in Situ or Skin Cancer will be accepted as evidence that cancer exists when a Pathological Diagnosis cannot be made, provided medical evidence substantially documents the Diagnosis of Life Threatening Cancer, Carcinoma in Situ or Skin Cancer.

### Practical Interpretation

Type of Diagnosis	Conditions
Pathological	<ul style="list-style-type: none"><li>■ a pathologist studies fixed tissue or blood under a microscope; and</li><li>■ the diagnosis meets American College of Pathology standards.</li></ul>

## Legally Qualified Physician

### Policy Definition

Legally Qualified Physician means a person, other than the Insured or the Owner, a member of the Insured's or the Owner's immediate family, or a business associate of the Insured or Owner, who is duly licensed and practicing in the United States or its possession, Canada, or Mexico, and who is legally qualified to diagnose and treat sickness and injuries. He or she must be providing services within the scope of his or her license.

### Practical Interpretation

A Legally Qualified Physician:

Is:

- licensed and practicing medicine in the United States or its possessions, Canada, or Mexico
- legally qualified to diagnose and treat sickness and injuries; and
- providing services within the scope of his or her license.

Is not:

- the insured or the person or entity the insured assigns as owner;
- a member of the insured's or owner's immediate family; or
- the insured's or owner's business associate.

## Basic Hospital Insurance

Basic hospital insurance is an insurance policy which provides coverage subject to no deductible in excess of \$500 for a period of not less than 60 days for any continuous hospital confinement of each covered person for services rendered while confined in a hospital (except as to subdivision (c) below) or, in the case of an article IX-C corporation for services rendered while confined in a member hospital, for necessary treatment because of sickness or injury for at least:

- (a) Daily room and board, consisting of bed and board, including general nursing care and special diets, in an amount not less than the lesser of:
  - (1) 80 percent of the charges for semi-private accommodations;
  - (2) 100 percent of the charges for semi-private accommodations for the first 20 days of confinement and at least 50 percent of such charges for the next 40 days; or
  - (3) \$240 per day; except that such \$240 may be reduced to \$165 for policies issued for delivery outside the metropolitan area;
  
- (b) Miscellaneous hospital services, during each period of continuous hospital confinement as an inpatient, in an amount not less than 80 percent of the charges incurred, up to at least \$5,000 or 20 times the daily room and board rate if specified in dollar amounts for at least:
  - (1) the use of operating, recovery and cystoscopic rooms and equipment;
  - (2) the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;
  - (3) diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;
  - (4) dressings and plaster casts;
  - (5) supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person;
  - (6) radiation therapy and chemotherapy; and
  - (7) any medical services and supplies which are customarily provided by hospitals unless specifically excluded in the insurance or subscriber contract and the individual certificates issued in connection with group insurance; and
  
- (c) Outpatient services, consisting of:
  - (1) hospital services on the day surgery is performed;
  - (2) hospital services rendered within 24 hours after accidental injury, in an amount not less than the lesser of the reasonable charges incurred or the per-day amount provided for daily room and board if specified in dollar amounts under subdivision (a) of this section; and
  - (3) with respect to individual insurance written by insurers other than article IX-C corporations, X-ray and laboratory tests performed in the outpatient department of a hospital, to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital.

## Major Medical Insurance

Major medical insurance is an insurance policy which provides coverage for each covered person, to a maximum of not less than \$100,000; co-payment by the covered person not to exceed 25 percent; a deductible stated on a per-person, per-family, per-illness, per-benefit period, or per-year basis, or a combination of such bases, not to exceed five percent of the lowest overall maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance, in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for at least:

- (a) daily room and board, as defined in subdivision (a) of section 52.5 of this Part;
- (b) miscellaneous hospital services, as defined in subdivision (b) of section 52.5 of this Part; provided, however, that the maximum amount limitation shall not apply;
- (c) surgical services, as defined in subdivision (a) of section 52.6 of this Part;
- (d) anesthetic services, as defined in subdivision (b) of section 52.6 of this Part;
- (e) in-hospital medical services, as defined in subdivision (c) of section 52.6 of this Part;
- (f) mental health care consisting of coverage for diagnosis and treatment of mental illness for at least:
  - (1) 30 days per year of inpatient care in a hospital as defined by subdivision ten of section 1.03 of the Mental Hygiene Law;
  - (2) 30 outpatient visits per year at no less than \$30 per visit and a yearly maximum of no less than \$1,500 with reimbursement for early visits greater than or at least equal to reimbursement for subsequent visits in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article 31 of the Mental Hygiene Law, or in a facility operated by the office of mental health, or by a psychiatrist or psychologist licensed to practice in this state, or a professional corporation thereof; and
  - (3) Outpatient crisis intervention services consisting of at least three psychiatric emergency visits per year. Upon certification, by a licensed mental health care provider whose services are covered under the policy, that a visit was the result of a psychiatric emergency (one where the person appears to have a mental illness for which immediate observation, care and treatment is appropriate and which is likely to result in serious harm to himself/herself or others), benefits for such a visit shall be no less than \$60 per visit. However, benefits provided under this paragraph may be used to reduce benefits otherwise payable under paragraph (1) or (2) of this subdivision.
- (g) out of hospital care, consisting of physicians' services rendered on an ambulatory basis, where coverage is not provided elsewhere in the policy, for diagnosis and treatment of sickness or injury, including the cost of drugs and medications available only on the prescription of a physician, and diagnostic X-ray, laboratory services, radiation therapy, chemotherapy and hemodialysis ordered by a physician; and
- (h) prosthetic appliances, meaning artificial limbs or other prosthetic appliances (including replacements thereof which are functionally necessary), and rental or purchase (at insurer's option) of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement.