POLICYHOLDER NAME:	Truckers Service Association		
POLICYHOLDER ADDRESS:	2271 E Continental Blvd. Ste. 120 Southlake, TX 76092		
INSURER NAME:	Beazley Insurance Company, Inc.		
INSURER ADDRESS: **ADMINISTRATIVE OFFICE**	c/o The Loomis Company 850 N. Park Road P.O. Box 7011 Wyomissing, PA 19610-6011		
INSURER ADDRESS: **NOTICE OF CLAIM**	c/o The Loomis Company 850 N. Park Road P.O. Box 7011 Wyomissing, PA 19610-6011		
POLICY NUMBER:	IB0165	**EFFECTIVE DATE:**	October 1, 2020
DATE OF ISSUE:	October 1, 2020	**ANNIVERSARY DATE:**	October 1

In consideration of the Policyholder's application and the timely payment of premiums, Beazley Insurance Company, Inc. (herein called the Company) agrees to pay the benefits of this Policy, subject to all of its terms and conditions.

This Policy is executed by Beazley Insurance Company, Inc. as of its Date of Issue. This Policy will take effect on the Effective Date shown above, 12:01 a.m. Standard Time at the address of the Policyholder.

Wayne K. Whitten

Secretary

President

NON-PARTICIPATING SPECIFIED DISEASE POLICY

THIS IS A LIMITED POLICY. THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED DISEASES LISTED. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

This Policy is a contract between the Policyholder and the Company.

BENEFIT REDUCTION AT AGE 70

No benefits will be provided for Cancer diagnosed before the 30th day after the Effective Date.

READ YOUR POLICY CAREFULLY.

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SCHEDULE OF BENEFITS

ELIGIBILITY: ALL PERMANENT MEMBERS, WORKING 15 HOURS OR MORE PER WEEK AND ACTIVELY IN SERVICE AND SPOUSES OR DOMESTIC PARTNERS AND/OR DEPENDENT CHILD(REN) OF ELIGIBLE MEMBERS

WAITING PERIOD:

Cancer	30 Days
Other Specified Disease	None

PRE-EXISTING CONDITION PERIOD: ..... 12 Months

SPECIFIED DISEASE MAXIMUM BENEFIT AMOUNT:

Member	as listed in Certificate
Member's Spouse or Domestic Partner	as listed in Certificate
Member's Dependent Child(ren)	as listed in Certificate

REDUCED BENEFIT SCHEDULE

Reduction Amount:	50%
Reduced Benefit Age:	70

SPECIFIED DISEASE	**% PAYABLE**
Cancer	100%
Heart Attack	100%
Stroke	100%
Coma	100%
Coronary Artery Bypass	25%
Loss of Sight	100%
Organ Transplant	100%
Paralysis	100%
Renal Failure	100%
Severe Burns	100%

ADDITIONAL OCCURRENCE BENEFIT

% of Specified Disease Benefit Amount	100%
Occurrence Separation Period	6 Months

RECURRENCE BENEFIT

% of Specified Disease Benefit Amount	25%
Recurrence Separation Period	6 Months

HEALTH SCREENING BENEFIT $50

RATE GUARANTEE PERIOD: 1 Year

DEFINITIONS

ACTIVELY IN SERVICE means that the Member is:

(1) performing in the usual manner, all of the Material and Substantial Duties of his or her employment for the regularly scheduled number of hours on a scheduled work day; and

(2) the Material and Substantial Duties are being performed at one of the places of business where the Member normally performs such duties or at some location to which the Member's employment sends him or her.

The Member will be said to be Actively in Service on a day that is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of the Member's employment if it were a scheduled work day.

CANCER means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia and Lymphoma. Excluded are Cancers such as:

(1) Benign tumors or polyps;

(2) Pre-malignant tumors or polyps;

(3) Carcinoma in Situ (non-invasion);

(4) Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;

(5) Any skin cancers except invasive malignant melanoma or skin malignancies that have become metastatic;

(6) Basal cell carcinoma and squamous cell carcinoma of the skin; and

(7) Melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.77mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer must be diagnosed pursuant to a Pathological Diagnosis or a Clinical Diagnosis. A Clinical Diagnosis will be accepted as evidence that Cancer exists in an Insured only when:

(1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;

(2) there is medical evidence to support the diagnosis; and

(3) a Physician is treating the Insured for Cancer.

CERTIFICATE means the individual Certificate issued to the insured Member. It describes the Insured's coverage under the Policy.

CLINICAL DIAGNOSIS means a diagnosis of Cancer based on the study of symptoms.

COMA means a state of unconsciousness, where no reaction to external stimuli is seen and no reaction to internal needs are noted, that requires the use of life support systems. The Coma must be caused by severe brain trauma and the Coma must last for 14 consecutive days. The condition must require intubation for respiratory assistance.

CORONARY ARTERY BYPASS means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, at the advice of a Physician board certified in cardiology. Coronary Artery Bypass excludes procedures such as, but not limited to balloon angioplasty, laser relief, stents or other non-surgical procedures.

DATE OF DIAGNOSIS means:

For Cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based.

For Heart Attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For Stroke: The date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

For Organ Transplant or Coronary Artery Bypass: The date the surgery occurs for covered transplants or covered Coronary Artery Bypass surgery.

For Renal Failure: The date that a Physician recommends that an Insured begin renal dialysis.

For other Specified Diseases: The date the diagnosis, consistent with the definition of the Specified Disease, is established by a Physician based on clinical and/or laboratory findings as supported by the insured's medical records.

DEPENDENT CHILD(REN) means all of a Member's children who are unmarried and less than 26 years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age limit of 26 shall not apply. Proof of such incapacity and dependency must be furnished to the Company within 31 days following the Child's 26th birthday, and not more frequently than annually from then forward.

Child(ren) means the Member's biological children, stepchildren, adopted children, foster children or any child for whom the Member is required by a court or administrative order to provide health coverage.

DOMESTIC PARTNER means a person of the same or opposite sex who:

(1) is at least 18 years old and legally capable to enter into a contract;

(2) is not related by blood to the Member more closely than is permissible for marriage in the state of residence;

(3) is not married or legally separated;

(4) has not been party to an action or proceeding for divorce or annulment within the last 6 months, or has been a party to such an action or proceeding and at least 6 months have

elapsed since the date of the judgment terminating the marriage;

(5) is not currently in a domestic partnership with a different domestic partner and has not been in such a relationship for at least 6 months;

(6) occupies the same residence as the Member;

(7) has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and

(8) has entered into a Domestic Partnership Agreement with the Member.

DOMESTIC PARTNERSHIP AGREEMENT means an arrangement between the Member and another person of the same or opposite sex that includes 3 of the following:

(1) joint lease, mortgage or deed;

(2) joint ownership of a vehicle;

(3) joint ownership of a checking account or credit account;

(4) designation of the Domestic Partner as the beneficiary of the Member's life insurance or retirement benefits;

(5) designation of the Domestic Partner as the beneficiary of the Member's will;

(6) designation of the Domestic Partner as holding power of attorney for health care; and

(7) shared household expenses.

EFFECTIVE DATE means the date described in the Policy. The date shown in the insured Member's individual Certificate will be the Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

HEALTH SCREENING TEST means any of the following performed by a Physician:

(1) Stress test on a bicycle or treadmill;
(2) Biopsy for skin Cancer;
(3) Fasting blood glucose test;
(4) Blood test for triglycerides;
(5) Serum cholesterol test to determine level of HDL and LDL;
(6) Bone marrow testing;
(7) Breast ultrasound;
(8) Cartoid Doppler;
(9) CA 15-3 (blood test for breast cancer);
(10) CA 125 (blood test for ovarian cancer);
(11) CEA (blood test for colon cancer);
(12) Chest X-ray;
(13) Colonoscopy;
(14) Electrocardiogram (EKG);
(15) Flexible sigmoidoscopy;
(16) Hemocult stool analysis;
(17) Mammography;
(18) Pap smear, including ThinPrep Pap Test;

(19) PSA (prostate specific antigen - blood test for prostate cancer);
(20) Serum Protein Electrophoresis (blood test for myeloma);
(21) Thermography.

HEART ATTACK means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

(1) New and serial Electrocardiographic (EKG) findings consistent with myocardial infarction;

(2) Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine physphokinase (CPK), a CPK-MB measurement must be used;

(3) Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms; and

(4) Chest Pain.

INJURY means bodily injury solely due to an accident. It includes all complications of and all Injuries from the same accident. The accident must occur and any Specified Disease resulting from the Injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

INSURED(S) means the Member, the Spouse or Domestic Partner of a Member and the Dependent Child(ren) of the Member as indicated in the Certificate Schedule.

LOSS OF SIGHT means the irreversible loss of sight in both eyes. The diagnosis of Loss of Sight must:

(1) be made by a Physician, and

(2) indicate the corrected visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.

MATERIAL AND SUBSTANTIAL DUTIES means the duties that are:

(1) are normally required for the performance of the Member's employment; and

(2) cannot be reasonably omitted or modified.

MEMBER means a person who is Actively in Service and a member of the Policyholder.

ORGAN TRANSPLANT means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

PARALYSIS means complete and permanent loss of function of two or more limbs for a continuous period of at least 90 days. Paralysis excludes loss of function following a Stroke.

PATHOLOGICAL DIAGNOSIS means a diagnosis of 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 Pathologist whose diagnosis of malignancy conforms to the standards set by the American Board of Pathology.

PATHOLOGIST means a Physician who is licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

PHYSICIAN means a practitioner of the healing arts who:

(1) is practicing within the scope of his or her license in the state where so licensed; and

(2) is not related to the Insured.

POLICY means the Policy issued to the Policyholder that covers the Insured.

POLICYHOLDER means the employer, association or other organization who holds the Policy.

PRE-EXISTING CONDITION means any sickness, disease or physical condition for which the Insured has:

(a) had Treatment; or

(b) received a diagnosis or advice from a Physician,

during the Pre-Existing Condition Period indicated in the Schedule of Benefits, immediately before the Effective Date of coverage.

RENAL FAILURE means the end stage Renal Failure presenting as chronic, irreversible failure of both kidneys to function. The Renal Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or result in kidney transplantation. Renal Failure caused by a traumatic event, including surgical traumas, is excluded from coverage.

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SEVERE BURNS means third degree burns covering at least 20% of the surface area of the body.

SPECIFIED DISEASE means the conditions shown in the Schedule and as defined in this Policy.

SPOUSE means the person recognized as the Member's spouse under the laws of the state in which the Member resides.

STROKE means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident. Stroke does not include head injury, Transient Ischemic Attacks, chronic cerebrovascular insufficiency or attacks of Verterbrobasilar Ischemia.

TREATMENT means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All Members who:

(1) meet the definition of Actively in Service;

(2) qualify as eligible Insureds as defined in the Policyholder's application; and

(3) meet the definition of Eligibility as stated in the Schedule,

are eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

ELIGIBILITY OF DEPENDENTS

An eligible Member may enroll his or her Spouse or Domestic Partner and/or Dependent Child(ren). An individual cannot be covered as a Member and a Spouse or Domestic Partner at the same time. A Dependent Child may only be covered by one Member if both parents are Members and covered separately under the Policy.

EFFECTIVE DATE

The Effective Date for a Member is as follows:

(1) A Member's coverage will be effective on the date shown on the Certificate Schedule provided the Member is then Actively in Service.

(2) If a Member is not Actively in Service on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Member is first thereafter Actively in Service.

The Effective Date for a Spouse or Domestic Partner and/or Dependent Child(ren) is the date shown on the Certificate Schedule subject to the following:

(1) The date the Member's coverage is effective for a Spouse or Domestic Partner and/or Dependent Child(ren) who is/are eligible on that date; for whom coverage is applied for and premium paid; and who is/are not hospital confined.

(2) At 12:00 a.m. Standard Time, on the day a Spouse or Domestic Partner and/or Dependent Child(ren) is/are no longer hospital confined if the Spouse or Domestic Partner and/or Dependent Child(ren) was/were otherwise eligible for coverage on the date the Member's coverage became effective.

(3) For a dependent eligible on or first acquired after the Member's Effective Date, the Effective Date will be:

(a) For newborn children and newborn adopted children, the Effective Date is the moment of birth. The Company must receive notification of birth within 60 days after the date of birth for coverage to continue for the newborn beyond the 60 day period. For newborn adopted children, a decree of adoption must be entered, unless extended by order of the court, and custody must continue pursuant to the decree of the court.

(b) For other adopted children and foster children, the Effective Date is the date of placement in the Member's home. For adopted children, a decree of adoption must be entered, and the Member must continue to have custody pursuant to the decree of the court. The Company must receive notification of newly adopted children and foster children within 60 days from the date of placement into the Member's home for coverage to continue for the adopted children and foster children beyond the 60 day period.

(c) For a Spouse or Domestic Partner or any other dependent eligible on or first acquired after the Member's Effective Date, the Effective Date is the date we assign after approving that application for his or her coverage.

BENEFITS

SPECIFIED DISEASE BENEFIT

The Company will pay this benefit if an Insured is diagnosed with one of the Specified Diseases shown on the Schedule if:

1. The Date of Diagnosis is after the Waiting Period;
2. The Date of Diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the Date of Diagnosis of Specified Disease occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Maximum Benefit Amount is shown in the Schedule. The benefit amount paid for a Specified Disease will be calculated by multiplying the Maximum Benefit Amount by the % Payable listed on the Schedule for the Specified Disease with which the Insured is diagnosed. If, on the Date of Diagnosis, the Insured's age exceeds the age listed on the Schedule under the Reduced Benefit Schedule, the benefit amount will be reduced by the Reduction Amount percentage listed under the Reduced Benefit Schedule. Benefits will be based on the Maximum Benefit Amount in effect on the Date of Diagnosis.

Benefits for Specified Disease will be paid in the order the events occur. If more than one Specified Disease is diagnosed at the same time, only one benefit amount will be paid.

ADDITIONAL OCCURRENCE BENEFIT

No benefits are payable for a subsequent, different Specified Disease after the first Specified Disease has been diagnosed unless its Date of Diagnosis is separated from the Date of Diagnosis of the prior Specified Disease by at least the Occurrence Separation Period listed in the Schedule.

The benefit amount paid for a subsequent, different Specified Disease will be calculated by multiplying the product of the Maximum Benefit Amount and the % Payable for the Specified Disease listed on the Schedule, by the % listed under the Additional Occurrence Benefit on the Schedule. If, on the Date of Diagnosis, the Insured's age exceeds the age listed on the Schedule under the Reduced Benefit Schedule, the benefit amount will be reduced by the Reduction Amount percentage listed under the Reduced Benefit Schedule. Benefits will be based on the Maximum Benefit Amount in effect on the Date of Diagnosis.

RECURRENCE BENEFIT

Once benefits have been paid for a Specified Disease, no additional benefits are payable for a subsequent diagnosis of that same Specified Disease unless the Dates of Diagnosis are separated by at least at least the Recurrence Separation Period listed in the Schedule.

The benefit amount paid for a subsequent diagnosis of the same Specified Disease will be calculated by multiplying the product of the Maximum Benefit Amount and the % Payable for the Specified Disease listed on the Schedule, by the % listed under the Recurrence Benefit on the Schedule. If, on the Date of Diagnosis, the Insured's age exceeds the age listed on the Schedule under the Reduced Benefit Schedule, the benefit amount will be reduced by the

Reduction Amount percentage listed under the Reduced Benefit Schedule. Benefits will be based on the Maximum Benefit Amount in effect on the Date of Diagnosis.

HEALTH SCREENING BENEFIT

The Company will pay this Benefit for Health Screening Tests performed while this Policy is in force. The Company will pay up to the amount shown in the Certificate Schedule for the Health Screening Tests once per 12 month period for each Insured. There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Policy is in force.

Payment of this benefit will not reduce the Maximum Benefit Amount shown in the Schedule. The Company will pay this benefit regardless of the results of the test.

LIMITATIONS

WAITING PERIOD

No benefits are payable for any Insured who has been diagnosed with a Specified Disease before their coverage has been in force for the number of days listed as the Waiting Period in the Schedule of Benefits. If an Insured is first diagnosed with a Specified Disease within the Waiting Period, they may elect to terminate coverage retroactive to the Effective Date and a full refund of premium will be provided.

PRE-EXISTING CONDITION LIMITATION

The Company will not pay benefits for any Specified Disease diagnosed within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition.

If the Insured was covered under the prior carrier's group specified disease policy at the date of change in coverage to a group specified disease policy provided by the Company, and was not subject to a Pre-Existing Condition limitation under the prior carrier's policy, there shall be no Pre-Existing Condition limitation under the Company's policy. However, if the Insured was subject to a Pre-Existing Condition limitation under the prior carrier's policy, credit will be given toward satisfaction of the Pre-Existing Condition limitation of the Company's policy for that period of time that the Insured was continuously covered under the prior carrier's policy.

A claim for benefits for a Specified Disease diagnosed after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

EXCLUSIONS

This Policy does not provide benefits for Specified Disease that results from:

(1) Intentionally self inflicted Injury or suicide attempt while sane;

(2) an act of war, declared or undeclared;

(3) active participation in a riot, civil commotion, civil disobedience or unlawful assembly;

(4) committing a felony;

(5) air travel, except as a fare-paying passenger on a commercial airline;

(6) drug addiction or dependence upon any controlled substance; or

(7) the Insured being intoxicated or under the influence or any narcotic unless the narcotic is administered on the advice of a Physician.

TERMINATION OF INSURANCE

A Member's coverage will terminate on the earliest of:

(1) the date the Policy is terminated;

(2) the end of the last period for which premium has been paid;

(3) on the date he or she ceases to be Actively in Service as defined in the Policy;

(4) on the date he or she no longer meets the requirements for eligibility; or

(5) on the date all available benefits under the Certificate have been paid.

Coverage for an insured Spouse or Domestic Partner and/or Dependent Child(ren) will terminate the earliest of:

(1) the date the Policy is terminated;

(2) the date the Member's coverage is terminated;

(3) the end of the last period for which premium has been paid;

(4) the premium due date following the date the Spouse or Domestic Partner and/or Dependent Child(ren) ceases to meet the definition of Spouse or Domestic Partner and/or Dependent Child(ren);

(5) the premium due date following the date the Company receives the Member's written request to terminate coverage for his or her Spouse or Domestic Partner and/or Dependent Child(ren).

Termination of Insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

The Company or the Policyholder may end the Policy on any date by written notice mailed or delivered. If the Company ends the Policy for a reason other than non-payment of premium, the termination becomes effective on the later of the date stated in the notice or 45 days after the Company mails or delivers the written notice of such termination. If any portion of the premium due is not paid, the Policy will terminate in accordance with the Grace Period provision. If the Policyholder ends the Policy, the termination becomes effective on the later of the date stated in the notice or the date the Company receives the written notice of such termination. If the Policy is ended, the Company will promptly refund any unearned premium, or the Policyholder will promptly pay any earned premium which has not yet been paid. Any unearned and earned premium will be calculated on a pro-rata basis.

Except for non-payment of premium or failure to meet underwriting standards, the Company may not terminate the Policy prior to the first anniversary date of the Effective Date of the Policy.

Termination of the Policy will be without prejudice to the rights of any Insured as respects any claim arising during the period the Policy is in force.

The Policyholder has the sole responsibility to notify Members of such termination.

PREMIUM CALCULATION AND PAYMENT

Premiums will be computed in accordance with the rates in effect on the Premium due date. The total premium for the Policy is the sum of premiums for all Insureds.

The first premium is due on the Effective Date of this Policy. Premiums after the first are due at the end of the period for which the preceding premium was paid. The due date for any additional premium for a dependent eligible on or first acquired after the insured Member's Effective Date will be 60 days after coverage for that dependent is required to begin.

The Policyholder is responsible for paying all premiums. However, the premiums may be paid by any other party according to a mutual agreement among the other party, the Policyholder and the Company.

Premiums may be paid to:

(1) the Company's Home Office; or

(2) the Company's authorized agent.

Payment of premium for a period before it is due will not guarantee that the coverage will remain in that effect for that period.

The rates may be changed once the Rate Guarantee Period listed in the Schedule has elapsed after the Effective Date of the Policy or on any Premium due date after that. Any subsequent rate changes will not be made more frequently than once every 12 months. No such change in premium will be made unless 60 days prior notice is given to the Policyholder.

The rates may change prior to the time frames outlined above, however, for reasons that affect the insured risk, which include:

(1) a change in benefits;

(2) a new law or change in any existing law that affects the Policy; or

(3) a material change in the composition or size of the Insureds covered under the Policy.

GRACE PERIOD

A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will remain in effect during the grace period. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder must still pay all unpaid premium. This includes the premium due for the grace period. No grace period is provided after the Policyholder has given notice of intent to end the Policy.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to the Company at the address listed on the first page of this Policy, or to the Company's designee. Such notice should be made within 30 days after any claim covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

CLAIM FORMS: Claim forms should be used for filing proof of loss. The Company shall furnish to the Insured, or to the Policyholder for delivery to the Insured, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Company receives notice of any claim under the Policy, the Insured shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

PROOF OF LOSS: Proof of loss must be given to the Company within 180 days after the loss. Late proof may be accepted if:

(1) it was not reasonably possible to give proof in that time; and

(2) the proof is given within one year from the date proof is otherwise required. This one year limit will not apply in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy will be paid not more than 30 days after the Company receives acceptable Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be payable in a lump sum to the Member unless assigned by them or by operation of law. Any accrued benefit unpaid at the Member's death may be paid to their estate.

PHYSICAL EXAMINATION: The Company has the right to have the Insured examined as often as is reasonably necessary while a claim is pending. The Company will pay for such examination. In the case of death, the Company may also have an autopsy done, at the Company's expense, unless prohibited by law.

GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

(1) the Policy;

(2) the application of the Policyholder;

(3) the Certificates;

(4) the insured Member's application, if any, attached to the Certificate; and

(5) all riders, endorsements and amendments.

The terms of the Policy can be changed only by rider, endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

CERTIFICATES: An individual Certificate will be issued for delivery to the insured Member. The Certificate will describe:

(1) the benefits under the Policy;

(2) to whom benefits will be paid; and

(3) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to the insured Member, only the last one issued will be in effect.

If there is a conflict between the Policy and the Certificate, the Policy will control.

ADDITIONAL COVERAGE WITH THE COMPANY: If an Insured is covered by more than one of the Company's Specified Disease Policies or Certificates, the Company will only pay benefits for a covered Specified Disease under one Specified Disease Certificate. An Insured may choose which Certificate they wish to keep in force by sending the Company written notice of their choice. The Company will return the premiums paid for any of its other Specified Disease Certificates during the period there was more than one Policy or Certificate in force.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

(1) within 60 days after written Proof of Loss has been furnished as required; or

(2) more than 3 years from the time written Proof of Loss is required to be furnished.

TIME LIMIT ON CERTAIN DEFENSES: Except in the case of fraud, after two years from the Effective Date of the Insured's coverage, no statements made in the application can be used to:

(1) void the coverage; or

(2) deny a claim for loss incurred commencing after the expiration of such two-year period.

INCONTESTABILITY: All statements made by the Policyholder to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder. After two years from the Effective Date, no such statement will cause this Policy to be contested except for fraud.

All statements made by an Insured are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the Insured. In the event of an Insured's death or incapacity, his or her applicable representative shall be given a copy.

After two years from an Insured's Effective Date of coverage, or from the Effective Date of increased benefits, no such statement will cause the coverage or the increased benefits to be contested except for fraud.

CLERICAL ERROR: A clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

MISSTATEMENT OF AGE: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

NEW ENTRANTS: New Members of the Policyholder and their dependents will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

IMPORTANT NOTICE: For questions regarding this Policy, please contact the Company at the administrative office listed on first page of this Policy. The Company may also be contacted by telephone at 1-866-218-6020.

BEAZLEY INSURANCE COMPANY, INC.

Missouri Amendatory Endorsement

This amendment modifies insurance coverage provided under the following:

NON-PARTICIPATING SPECIFIED DISEASE CERTIFICATE

NON-PARTICIPATING SPECIFIED DISEASE POLICY

This Amendment is attached to and made part of the Certificate effective as of the Certificate Effective Date. This Amendment is subject to all of the provisions, limitations and exclusions of the Policy except as specifically modified by this Amendment.

I. **FACE PAGE**, the statement "No benefits will be provided for Cancer diagnosed before the 30th day after the Effective Date." is deleted.

II. **SCHEDULE OF BENEFITS**, the **WAITING PERIOD** is deleted**.**

III. **DEFINITIONS**, the definition of **INJURY** is replaced by the following:

INJURY means bodily injury solely due to an accident. It includes all complications of and all Injuries from the same accident. The accident must occur and any Specified Disease resulting from the Injury must begin while Your coverage is in force.

III. **BENEFITS**, the **SPECIFIED DISEASE BENEFIT** is replaced by the following**:**

SPECIFIED DISEASE BENEFIT

The Company will pay this benefit if an Insured is diagnosed with one of the Specified Diseases shown on the Schedule if:

1. The Date of Diagnosis is while the Certificate is in force; and
2. It is not excluded by name or specific description in the Certificate.

The Maximum Benefit Amount is shown in the Schedule. The benefit amount paid for a Specified Disease will be calculated by multiplying the Maximum Benefit Amount by the % Payable listed on the Schedule for the Specified Disease with which the Insured is diagnosed. If, on the Date of Diagnosis, the Insured's age exceeds the age listed on the Schedule under the Reduced Benefit Schedule, the benefit amount will be reduced by the Reduction Amount percentage listed under the Reduced Benefit Schedule. Benefits will be based on the Maximum Benefit Amount in effect on the Date of Diagnosis.

Benefits for Specified Disease will be paid in the order the events occur. If more than one Specified Disease is diagnosed at the same time, only one benefit amount will be paid. No benefits are payable for a subsequent Specified Disease after the first Specified Disease has been diagnosed.

III. **LIMITATIONS**, **WAITING PERIOD** is deleted.

All other terms, conditions and exclusions of the Policy and Certificate remain unchanged. This Amendment is executed by Beazley Insurance Company, Inc.

Secretary

President