

Trustmark

Voluntary Benefit Solutions®

A Division of Trustmark Insurance Company

PO BOX 7937
LAKE FOREST IL 60045-7937

ADDRESS SERVICE REQUESTED

JANE A SMITH
2008 PRAIRIE RD
DALLAS TX 60600

ACCOUNT NUMBER: J286729
CERTIFICATE NUMBER: B49CBTX3

Dear JANE A SMITH:

Welcome to the Trustmark family. You have joined the many thousands of people all across the country who count on us for sound insurance protection. Serving people is a Trustmark tradition that started in 1913.

We wanted to take this opportunity to let you know that we are amending the terms of your contract. Your contract contains a definition of First Diagnosis. Although this definition will continue to apply, the first-time requirement for diagnosis will be waived for your coverage for all conditions except for cancer, if cancer is a covered condition under your contract. This means benefits can become payable even if you have been previously diagnosed with that condition, providing a new occurrence of that condition takes place after your effective date.

Please review the enclosed insurance contract and store it in a safe place for future reference.

Trustmark promises you prompt, reliable service. If you have questions for our Customer Care Team, please call (800) 918-8877, fax us at (847) 615-4943, or e-mail us at CustomerCare@trustmarksolutions.com. If you have questions regarding claims, please call (877) 201-9373. Our staff is available to answer questions, make changes or perform any other related services you may need. You may also visit us at our website at www.trustmarksolutions.com.

Be assured that Trustmark is committed to protecting your privacy, and we will treat your personal information with complete confidentiality. Enclosed is our Company statement regarding our privacy commitment.

Thank you for your confidence in us. We look forward to serving you for many years to come.

Sincerely,



Joseph L. Pray
President and Chief Executive Officer

Encl.

Best Doctors

Your Critical Illness policy includes access to Best Doctors at no cost to you. Use of Best Doctors as a medical resource is optional. It is not required to receive payment of a Critical Illness benefit. The choice is entirely up to you.

Best Doctors is not insurance, and it does not replace your current physicians.

Best Doctors will help you when and if you need it:

InterConsultation

Personalized and Comprehensive Medical Review

Best Doctors will perform an in-depth review of your medical situation, including complete medical history, gathering medical records and test results to confirm your diagnosis and ensure the best treatment plan is in place. Once the Best Doctors' team of specialists has reviewed your case, you and your physician will receive a detailed report. A Best Doctors Member Advocate will be available to assist you every step of the way.

FindBestDoc

Customized Search for Highly Skilled Specialists

Get tailored search of the Best Doctors global database of more than 50,000 world-class specialists. A Best Doctors Members Advocate will listen to your needs, identify your options and access the best care provider for your condition.

Best Doctors VIP Concierge

Trusted Advice, Caring Support

Best Doctors can assist you with hospital admittance and make medical appointments. Best Doctors will coordinate your care with the specialists involved and monitor treatment to ensure your medical priorities are met. Best Doctors VIP Concierge service ensures access to care when you are away from home

To use Best Doctors call (866) 904-0910. The information you share is confidential. It will not be passed on to your employer, your health insurance plan, or Trustmark.

Best Doctors, InterConsultation and FindBestDoc are registered trademarks of Best Doctors, Inc. in the United States and other countries.

Best Doctors programs and services are not insurance services. Trustmark is not endorsing the quality of any diagnosis or physician selected through this service. Best Doctors programs can be removed from the plan at any time without notice.

TRUSTMARK INSURANCE COMPANY
400 Field Drive
Lake Forest, Illinois 60045

**CRITICAL ILLNESS and CANCER
PROTECTION CERTIFICATE
SUPPLEMENTAL COVERAGE**

This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit Payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

A copy of the Policy is kept at Our home office. You may inspect it during regular business hours.

This Certificate was issued on the basis that the information on Your application was correct and complete. If any information on the application was not correct, write to Us within ten (10) days of receipt of this Certificate. An error or omission may result in loss of coverage as of its Effective date.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office or to Your agent within 30 days after the date You receive it. The Certificate will then be canceled and any Premium paid will be refunded.

Renewability: This Policy is guaranteed renewable to age 100. We will not change any provision of the Policy except that we may change Premium rates by class for all those insured under this policy form in Your state. But in lieu of changing Premium rates we may change Definitions for all those insured under this policy form in Your state. Any rate change or Definitions change would be approved by the appropriate governing authority in the state.

Please Note: Your Effective Date may differ from the Effective Date of the groups Policy.

FURTHER INFORMATION REGARDING YOUR COVERAGE IS GIVEN ON THE PAGES THAT FOLLOW. THIS CERTIFICATE IS EVIDENCE OF YOUR COVERAGE. IT IS NOT THE INSURANCE POLICY. ANY STATEMENT IN THIS CERTIFICATE WHICH CONFLICTS WITH THE POLICY IS VOID. THIS CERTIFICATE REPLACES ANY OTHER CERTIFICATE PROVIDING THE SAME TYPE OF COVERAGE WHICH TRUSTMARK MAY HAVE ISSUED TO YOU.


YOUR COVERAGE IS INSURED BY TRUSTMARK INSURANCE COMPANY. ALL CLAIMS SHOULD BE SUBMITTED TO TRUSTMARK AND ALL QUESTIONS REGARDING YOUR COVERAGE SHOULD BE DIRECTED TO TRUSTMARK.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS COMPENSATION SYSTEM.

PLEASE READ YOUR CERTIFICATE CAREFULLY. **THIS IS A LIMITED CERTIFICATE**



Joseph L. Pray
President and Chief Executive Officer



Shea Welch
Corporate Secretary

VCACIMETMEUTTXCV40000

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Trustmarks toll-free telephone number for information or to make a complaint at 1-800-918-8877.

You may also write Trustmark Insurance Company at:

**400 Field Drive
Lake Forest, IL 60045**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:

**P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771**

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

TX-NOTICE

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Trustmarks para informacion o para someter una queja al 1-800-918-8877.

Usted tambien puede escribir a Trustmark Insurance Company

**400 Field Drive
Lake Forest, IL 60045**

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

**P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771**

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

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**SCHEDULE
CRITICAL ILLNESS AND CANCER COVERAGE**

POLICYHOLDER: Trustmark Multiple Employer/Union Group Insurance Trust

PARTICIPATING UNION:

CERTIFICATE NUMBER: B49CBTX3

INSURED: JANE A SMITH

EFFECTIVE DATE: SEPTEMBER 01, 2014

INITIAL PREMIUM: \$XXX.XX

PREMIUM PAYABLE: SEMI-ANNUAL

COVERED PERSONS:

INSURED	JANE A SMITH
SPOUSE	ALAN J SMITH
CHILDREN	ANGELA A SMITH BILLY B ANDERSON ANDERSON C CHARLIE DANIEL D ANDERSON EMILY E ANDERSON FRANK F ANDERSON GREG G ANDERSON HENRY H ANDERSON JACKIE J ANDERSON

BENEFIT AMOUNT:	INSURED	SPOUSE	CHILD
	\$25,000 The first 12 months following the Effective Date		
	\$XXX.XX More than 12 months following the Effective Date		

PARTIAL BENEFIT AMOUNT: 25% of the Benefit Amount for either an initial diagnosis of Carcinoma In Situ or for Coronary Artery Bypass Surgery. This Partial Benefit Amount is payable only once.

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DEFINITIONS

Active Employee: An Insured who is:

- A Full-Time employee of employer;
- Performing the normal duties of Your job as a member of a Participating Union with an employer on a Full Time basis;
- Working the minimum number of hours established by employer for a Full-Time employee, which must be at least 20 hours per week;
- Working at Your employer's usual place of work or other place as required by employer in the course of such work; and
- Receiving a full rate of pay as set by the employment practices of Your employer or similar organizations.

You will be considered to be an Active Employee on a paid vacation day or regular non-working day if You were an Active Employee on Your last regular working day. You are considered an Active Employee if You are not performing Your usual job due to seasonal availability if You were an Active Employee on Your last regular working day.

Certificate: This booklet, including any attached applications for insurance, riders, endorsements, or amendments describing Your group insurance benefits.

Clinical Diagnosis: A diagnosis of Cancer based upon symptoms and diagnostic test results. We will regard as valid a Clinical Diagnosis of Cancer if and only if the following conditions are met:

Pathological Diagnosis cannot be made because:

- It is medically inappropriate or carries the potential for severe harm to the Covered Person; and
- Medical evidence exists to support the diagnosis; and
- A Physician is treating the Covered Person for Cancer.

Covered Person: A person listed on the Schedule as insured under this Certificate.

Cancer: Cancer is limited to the following:

Carcinoma In Situ: A Cancer that is in the natural or normal location and is restricted to the site of origin without invasion of neighboring tissues. Diagnosis of Carcinoma In Situ shall be based on Clinical Diagnosis, Pathological Diagnosis, or any type of appropriate diagnosis. Benefits for Carcinoma In Situ are limited to the Partial Benefit Amount specified in the Schedule of Benefits. Cancers such as the following are not considered Carcinoma In Situ:

- Basal cell carcinoma and squamous cell carcinoma of the skin; or
- Melanoma that is diagnosed as Clark's level I or level II or Breslow's classification less than 0.75 mm;
- Premalignant tumors or polyps.

The date of diagnosis is the date on which the tissue specimen, blood sample and/or titer, which form/s the basis for the diagnosis of Carcinoma In Situ, is/are taken. In the event that such studies do not provide the basis for the diagnosis, the date of diagnosis is the date a clinical or other appropriate diagnosis is made, based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

Invasive Cancer: A malignant tumor characterized by the abnormal and uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Invasive Cancer is a diagnosis of malignancy established by a Pathological Diagnosis, Clinical Diagnosis, or any type of appropriate diagnosis. Invasive Cancer includes Leukemia and Hodgkin's Disease. Cancers such as the following are not considered Invasive Cancer:

- Carcinoma In Situ;
- Basal cell carcinoma and squamous cell carcinoma of the skin; or
- Melanoma that is diagnosed as Clark's level I or II or Breslow's classification less than 0.75 mm;
- Premalignant tumors or polyps.

The date of diagnosis is the date on which the tissue specimen, blood sample and/or titer, which form/s the basis for the diagnosis of Invasive Cancer, is/are taken. In the event that such studies do not provide the basis for the diagnosis, the date of diagnosis is the date a clinical or other appropriate diagnosis is made. Diagnosis is to be made based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

Critical Illness: Critical Illness is limited to the following:

Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease): Motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a Physician makes a diagnosis based on generally accepted principles of medicine in the United States at the time diagnosis is made.

Blindness: A degree of loss of visual acuity that prevents a person from performing work requiring eyesight, based on best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye. The date of diagnosis of Blindness is the date on which a licensed ophthalmologist physically examines the Covered Person and certifies that the Covered Person has best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye.

Coronary Artery Bypass Surgery: The actual undergoing of bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease. Diagnosis of coronary heart disease must be made by accepted angiography testing.

Coronary Artery Bypass Surgery does not include balloon angioplasty, laser relief or other like procedures.

Heart Attack: An acute myocardial infarction (the ischemic death of an area of the heart muscle resulting from a reduced blood supply to that area) caused by a blockage of one or more of the coronary arteries. Such acute myocardial infarction must be confirmed by: (a) new electrocardiographic (EKG) findings consistent with myocardial infarction; and either (b) cardiac blood enzyme abnormalities such as abnormality in the CK-MB isoenzyme (Creatine Kinase-MB isomer) fraction; or (c) Troponin elevations; or other clinical information to support the diagnosis of heart attack, such as confirmatory imaging studies like thallium scans, MUGA scans, or stress echocardiograms. The date of diagnosis is the date of ischemic death of an area of the heart muscle, as confirmed by the above criteria. Diagnosis is to be made based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

Paralysis Of At Least Two Limbs (Paralysis): A complete and irreversible condition marked by loss of muscle function in two arms, two legs, or one arm and one leg. For the purpose of this Certificate the paralysis is the direct result of either a Sickness or an Injury.

Stroke: An acute cerebral vascular event producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit which persists for at least 30 days. Acute cerebral vascular event means infarction hemorrhage, or embolization of brain tissue from an extra-cranial source. In addition to permanent neurological deficit diagnosis of stroke shall be based on confirmatory neuroimaging studies. Diagnosis is to be made based on generally accepted principles of medicine in the United States at the time the diagnosis is made. The date of diagnosis of Stroke is the date on which a neurological impairment that has persisted at least 30 days is diagnosed.

This definition of Stroke and any other definition of a Critical Illness shall specifically exclude Transient Ischemic Attacks, Reversible Ischemic Neurological Deficit, and attacks of Vertebrobasilar Ischemia.

Renal Failure: The end stage of chronic, irreversible failure of both kidneys to function, for which regular renal dialysis or renal transplantation is performed.

Transplant of a Major Organ: The completion of an organ transplant procedure that is required due to failure of a major organ. Transplantation includes human-to-human transplant of the following organs only: heart; pancreas; lung or lungs; liver; or bone marrow and/or stem cells, either autologous or allogenic.

Dependent: A Dependent is:

Your Eligible Dependent whose coverage is in force.

Your child who has coverage in force, who has reached the limiting age for children but who is incapable of self-sustaining employment and is chiefly dependent on You for support and maintenance, if all other requirements for Eligible Dependents are met. You must give Us proof of the child's incapacity and dependency within 31 days after the date the limiting age is reached in order to continue his coverage. You may also be required, from time to time, to give proof of his continuing incapacity and dependency, but no more than once each year after initial proof is given. If proof is not given within 60 days of a request, his coverage will end 60 days after the request is made.

Effective Date: The date coverage under this Certificate becomes effective for a Covered Person. The Effective Date is shown on the Schedule.

Eligible Dependent: A person who is:

Your legally married spouse.

Your newly born child.

Your unmarried natural or legally adopted child, stepchild or child for whom you become a party in a suit for adoption, under age 26.

Your grandchild who is a dependent for federal income tax purposes.

Your unmarried child for whom a court has issued a medical support order which decrees that You must provide medical coverage.

Child as used above includes adopted children and stepchildren.

Eligible Dependent will not include:

- A foster child;
- A child or spouse whose primary residence is outside of the USA, its territories and possessions; or
- A child or spouse who is an Active Employee.

No person may be covered as the Dependent of more than one Active Employee. No person who is in an active duty status in any navy, military or air force may be covered under the Policy.

First Diagnosis: The first time a Physician identifies a Cancer or Critical Illness from its signs or symptoms. A diagnosis of Cancer or Critical Illness is based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

Full-Time: A regular workweek of at least 20 hours per week. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.

Immediate Family: Includes

- You or Your spouse; and
- Any of Your, or Your spouse's children, parents, grandparents, grandchildren, brothers, sisters, and their respective spouses.

Injury: Accidental bodily injury resulting directly and independently of disease, bodily infirmity or other cause.

Insured: The person named as the Insured on the Schedule.

Pathological Diagnosis: A diagnosis of Cancer based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. Pathological Diagnosis must be provided by a Physician who is also a board certified pathologist and whose diagnosis of malignancy is based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

Participating Union: The individual, entity or corporation named as the Participating Union on the Schedule. The Effective Date of the Participating Union may be different than the Covered Person's Effective Date.

Physician: An individual, other than You, or a member of Your Immediate Family, who is licensed to practice medicine or surgery for the treatment of Sickness and/or Injury in the state in which treatment is received.

Policy: The group contract issued to the Policyholder named on the Schedule, and any attached applications for insurance, riders or endorsements, or amendments describing Your insurance benefits. The provisions of the Policy govern this Certificate.

Policyholder: The Policyholder named on the Schedule.

Pre-existing Condition: During the twelve (12) months immediately prior to the Covered Persons Effective Date:

- A Sickness or Injury for which medical care, diagnosis or advice was received or recommended; or
- The existence of symptoms which would have caused an ordinarily prudent person to seek medical care, treatment, diagnosis or advice.

Sickness: Illness or disease that results in loss covered by this Certificate.

You and Your: The Insured named on the Schedule.

We, Us, Our, or the Company: Trustmark Insurance Company.

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ELIGIBILITY, EFFECTIVE DATE, RENEWAL AND TERMINATION

Eligibility for Coverage

Insured - You are eligible for coverage if Your application is approved by Us, and You are an Active Employee on the Effective Date of coverage.

Dependent - An Eligible Dependent is eligible for coverage on the later of:

The date You are eligible for insurance; or
The date You acquire the Dependent.

An Eligible Dependent is deemed to be acquired as follows:

Spouse: On the date of the marriage.

Natural Child: On the date of birth.

Adopted Child: On the date You become a party in a suit in which You seek adoption of the child.

Stepchild: On the date of the marriage.

Grandchild: On the date the child is a dependent for Federal Income Tax purposes.

Child For Whom Coverage Must Be Provided Pursuant to a Medical Support Order: On the date the court order or notification of the court order is received by Us.

Effective Date

Insured - Coverage will start at 12:00 a.m. standard time at Your home on the Effective Date shown on the Schedule.

Eligible Dependent -

Newborn: Coverage for a newborn is effective from the moment of birth for the first 31 days following birth. For coverage to continue beyond this 31-day period, You must notify Us of the birth of this child and pay any additional required premium.

Adopted Child: Coverage for an adopted child is effective from the date of You become a party in a suit in which You seek adoption of the child.

You must notify Us of Your becoming a party in a suit in which You seek adoption of the child within 45 days or before the end of the period for which Premium has been paid if later, and You must pay any additional Premium within 31 days of receiving a notice of the amount due.

If notification of an adopted child is received more than 45 days after the date You become a party in a suit in which You seek adoption of the child, coverage ends on the 46th day after that date. Insurance for the adopted child will become effective only if an application for coverage is approved by Us.

Child For Whom Coverage Must Be Provided Pursuant to a Medical Support Order: Coverage for a child for whom coverage must be provided pursuant to a medical support order is effective from the date we receive the medical support order or notification of the medical support order. For coverage to continue:

You must complete an application for the child within 31 days after the date we receive the medical support order or notification of the medical support order; and

You must pay any additional Premium within 31 days of receiving a notice of the amount due.

If application for such child is received more than 31 days after the date we receive the medical support order or notification of the medical support order, coverage ends on the 32nd day after such date. Insurance for that child will then become effective only if an application for coverage is accepted by Us.

Other Than A Newborn or Adopted Child or a Child For Whom Coverage Must Be Provided Pursuant to a Medical Support Order: You must complete and sign an application that includes Your Dependents. If approved by Us, Dependent coverage will be effective as follows:

The date Your insurance is effective for Eligible Dependents who are eligible on that date; for whom coverage is applied for and Premium paid; and who are not hospital confined.

At 12:00 a.m. standard time at Your home, on the day an Eligible Dependent is no longer hospital confined if they were otherwise eligible for coverage on the date Your insurance became effective.

For an Eligible Dependent eligible on or first acquired after your Effective Date:

If an application for Dependent coverage is received by Us, insurance will be effective on the date We assign.

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Termination of Coverage

Insured - Your coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

CACIM-82001C

The date of First Diagnosis for which the Benefit Amount **shown** on the Schedule is payable in full for You;
The end of the period for which Premium is paid, subject to the grace period;
The Premium due date following the date We receive Your written request to have your insurance terminated; or
The date the Policy is terminated.

Dependent - Dependent coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

The date of First Diagnosis for which the Benefit Amount shown on the Schedule is payable in full for that Dependent;
The end of the period for which Premium is paid, subject to the grace period;
The Premium due date following the date a Dependent ceases to be a Dependent as defined;
The date Your coverage terminates, except when Your termination is due to payment of the Benefit Amounts shown on the Schedule;
The Premium due date following the date We receive Your written request to terminate Dependent coverage for Your spouse and/or Dependent child/children; or
The date the Policy is terminated.

Continuation

Loss of Eligibility

If You are no longer working Full-time for Your Employer, coverage may be continued under the Certificate as long as:

the Policy is not terminated;
any Covered Person remains eligible for coverage, subject to the Termination of Coverage provisions;
and
Premium is paid when due, subject to the grace period.

You will be required to pay monthly premiums to Us, via Electronic Fund Transfer. We have the right to change the Premium rate on any Premium due date.

Continuation for Incapacitated Children

Dependent children, insured herein, that reach the limiting age and are incapable of self-sustaining employment due to mental or physical handicap may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once a year.

Coverage for a handicapped child will end on the earliest of:

The date the Dependent marries;
The date the Dependent obtains self-sustaining employment;
The date the Dependent ceases to be handicapped;
The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
Sixty (60) days after a written request for proof of handicap, if proof is not provided within such 60 days;
The date You refuse to allow Us to examine the Dependent;
The later of the date of First Diagnosis for which the Benefit Amount **shown** on the Schedule is **payable** in full or the date the remaining percentage of the Total Benefit Amount is paid following payment of a Partial Benefit Amount;
The Premium due date following the date We receive Your written request to terminate Dependent coverage for Your spouse and/or Dependent child/children;
The date coverage under their Certificate is otherwise terminated.
The date the Policy is terminated.

Dependent Continuation

If coverage ends due to divorce, a Dependent spouse may elect to continue coverage for him/herself and covered Dependent children. A divorced spouse may not elect to continue coverage for covered Dependent children unless the divorced spouse is also covered. If coverage ends due to attainment of the limiting age, a covered Dependent may elect to continue coverage.

Notice of this election must be received by Us within 60 days of the event. No evidence of insurability will be required. Premium for the continued coverage must be paid within 31 days after the election is made. Premium will be based on Our rates in effect at the time of continuation.

Suspension of Coverage During Military Service

If a Covered Person enters into active duty status for the military or naval service of the United States or any other country coverage is suspended as of the first date of active duty status. We request that you notify us within 30 days the first date of active duty status, however coverage will be suspended regardless of receipt of notification. When the Company receives notification of Your active duty status any required adjustment of Premium will be made including refund of Premium, if necessary.

Upon termination of active duty status, the Covered person may request a resumption of coverage if the person still meets the eligibility requirements. This request must:

- Be in writing;
- Be submitted within 60 days of the Covered Persons termination of active duty status; and
- Include the required Premium.

Coverage will then begin again on the date following termination of active duty status. Credit will be given for the Pre-existing Condition limitation period satisfied prior to the date of suspension.

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BENEFIT PROVISION

Subject to the Exclusions and Limitations and the provisions of the section entitled Partial Benefit Amount, We will pay the Benefit Amount as shown on the Schedule for a Covered Person, if:

- a First Diagnosis is made by a Physician after the Effective Date for a Covered Person; and said First Diagnosis is an appropriate diagnosis based on applicable x-ray, laboratory test or other recognized diagnostic procedures performed during the life of the Covered Person or postmortem, and is made based on generally accepted principles of medicine in the United States at the time the diagnosis is made.

The Benefit Amount shown on the Schedule will be paid for a First Diagnosis, except as provided under the Partial Benefit Payment provision. No more than one Benefit Amount will be paid for a Covered Person, even if a Covered person experiences more than one Critical Illness and/or Invasive Cancer.

Partial Benefit Payment:

A Partial Benefit Amount, as shown on the Schedule, will be paid for:

- a First Diagnosis of Carcinoma In Situ; or
- if the Covered Person has Coronary Artery Bypass Surgery.

Such diagnosis must be made or surgery performed after the Effective Date. A Partial Benefit Amount will be paid only once for either Carcinoma In Situ or Coronary Bypass Surgery for a Covered Person during that persons lifetime.

If a Covered Person receives the Partial Benefit Amount payment, the remaining percentage of the Benefit Amount will be payable if:

- the Covered Person should receive a First Diagnosis for Invasive Cancer or for a different Critical Illness other than Coronary Artery Bypass Surgery; and
- this Certificate remains in effect for the Covered Person.

In no event will the total amount paid for the two benefit payments exceed the Benefit Amount shown on the Schedule.

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EXCLUSIONS

No benefits will be paid for:

- A diagnosis made prior to the Effective Date, as applicable to the Covered Person;
- Basal cell carcinoma and squamous cell carcinoma of the skin; or
- Melanoma that is diagnosed as Clarkes level I or II or Breslows classification less than 0.75mm;

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Premalignant tumors or polyps;
Sickness caused by alcohol, drugs, narcotics, or hallucinogens not prescribed by a Physician, or not used in the manner prescribed by the Physician;
Any disease, Sickness or incapacity not specified in this Policy;
More than one First Diagnosis occurrence after the Effective Date, except as specified on the Schedule and under the Section entitled Benefit Provision;
Transient Ischemic Attacks, Reversible Ischemic Neurological Deficit, and attacks of Vertebrobasilar Ischemia.
Balloon Angioplasty, laser relief or other like procedures;
Any Invasive Cancer, Carcinoma In Situ or Critical Illness resulting from:
The Covered Persons commission of, or attempt to commit, a felony;
Self-inflicted injury, while sane or insane;
The Covered Persons committing or attempting to commit suicide;
The Covered Person engaging in an illegal occupation;
War or act of war, declared or undeclared;
The Covered Persons participation in a riot.

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PRE-EXISTING CONDITION LIMITATION

No Benefit Amount or Partial Benefit Amount will be paid for any condition caused by or resulting from a Pre-existing Condition which begins in the first twelve (12) months after the Covered Persons coverage Effective Date.

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PREMIUM

Payment of Premium

All premium, charges or fees (hereinafter Premium) must be paid to Us at Our home office. All Premium is payable in advance.

Due Date

The initial Premium is due on the Effective Date of coverage. Subsequent Premium is due on the Premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the grace period.

Returned or Dishonored Payment

If a check in payment for any Premium is dishonored for insufficient funds, a reasonable service charge shall be debited to You. A dishonored check shall be considered a failure to pay Premium.

Grace Period

If written notice of termination has not been received from You, a grace period of 31 days will be allowed for each Premium payment after the Initial Premium. Coverage shall remain in force during the grace period. If any Premium is unpaid at the end of the grace period, benefits paid for any claims incurred during the Grace Period will be reduced by the amount of the unpaid premium.

Reinstatement

If coverage ends for failure to pay Premium, You may apply for reinstatement. Such application must be in writing and submitted within 90 days from the date coverage ended. Reinstatement will be approved or disapproved within 45 days after our receipt of the application. If approved by Us, reinstatement coverage will become effective on the date We assign.

Premium Adjustment

We have the right to adjust the Premium as determined necessary by Us. A Premium adjustment will take effect on the next Premium due date following the adjustment.

If the Premiums vary by age, the change of a Covered person or Dependent from one age class to another will not be considered a change in Premium rates.

We also have the right to change the rates on any Premium due date following the effective date of any Premium tax law, or change to such law, applicable to this Contract. The amount of such change will be determined by the amount of change in the tax imposed. Any change due to a Premium tax will be separated from, and will not affect, any change in rates made under the terms described above.

Written notice of an adjustment will be mailed to You at least 30 days in advance.

When a Covered Persons coverage ends, any resulting change in Premium will be made on the next Premium due date.

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BENEFIT OR PREMIUM ADJUSTMENT

Premium Increase: If premium is paid through payroll deduction, The Insured must complete a new deduction authorization each time Premium is increased. Such authorization must be in writing and submitted to Your employer at least thirty (30) days prior to the date the Premium increase takes effect.

If an updated deduction authorization is not submitted on time, benefits will be reduced. The reduced benefit will be the amount of coverage the currently authorized deduction could purchase after the Premium increase.

Premium Decrease: If Premium is paid through payroll deduction, benefits will be increased in lieu of any Premium decrease. The increased benefit will be the amount of coverage the authorized deduction could purchase after the Premium adjustment.

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CLAIMS PAYMENT

Notice of Claim

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Policy number.

Claim Forms

When We receive the notice of claim, We will send You forms for filing a proof of loss. If these forms are not sent to You within 15 days, You will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Loss

Written proof of loss must be completed and returned to Us within 90 days or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date of First Diagnosis.

Payment of Claims

Benefits will be paid to You, unless assigned to a provider. Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian, at Our discretion, or as required by law. Any unpaid Premium that is due may be deducted from a claim. Payment of benefits will discharge Us from all liability.

Benefits will be paid to the Texas Department of Human Services for actual costs of medical expenses paid on behalf of a Covered Person by the Texas Department of Human Services. Benefits so paid will, in no event, exceed benefits otherwise payable to You.

Benefits will be paid to the Texas Department of Human Services on behalf of Your child if:

You are a possessory conservator of the child under a court order issued by a court in the State of Texas or if you are not entitled to possession of or access to the child and You are required by court order or court approved agreement to pay child support;

The Texas Department of Human Services is paying benefits on behalf of the child; and

We are notified in writing through an attachment to the claim for benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

Any requirements imposed on a possessory or managing conservator of the child shall not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised in accordance with Policy provisions or otherwise, nor to claims submitted by You where You have paid any portion of a medical bill that would be covered under the terms of the Policy.

Time of Payment of Claims

After We receive written proof of loss, We will immediately pay any benefits due.

Fraudulent Claim Submission

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains intentionally and materially false or misleading information, We shall have the right to rescind that Covered Persons coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

Medical Records and Examinations

With written authorization, We may obtain a Covered Persons medical records. We have the right, at Our expense, to have a Covered person examined as often as reasonably necessary while a claim on that Covered Person is pending. We have the right to have an autopsy performed, at Our expense, unless prohibited by applicable state law.

Facility of Payment

If the Covered Person does not survive, benefits will be paid to the first of the following beneficiary classes in which there is a surviving person:

- The Covered Persons legally married spouse;
- The Covered Persons children;
- The Covered Persons parents;
- The Covered Persons brothers and sisters;
- The Covered Persons executors or administrators.

The Company may require affidavits or statements it deems necessary in making payment under this provision. The Companys decision from such information will be final. The Company may, at its option, first pay up to \$1,000.00 of any benefits to any person the Company deems to be entitled thereto by reason of having incurred funeral or other expenses related to the last illness or death of the person insured.

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GENERAL PROVISIONS

Entire Contract

This Policy, including Your application for coverage, any endorsements, and any attached papers constitutes the entire contract. No change shall be valid until approved by an executive officer of the Company and endorsed or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Statements in the Application

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless:

- the statement is contained in an application; and
- a copy of the statement is furnished to You.

Time Limit on Certain Defenses

After coverage has been in force during a persons lifetime for 2 years from the Effective Date of coverage, only fraudulent misstatements in the application for this Policy may be used to void it or to deny any claim that is first diagnosed after the 2 year period. This does not affect the Policy or deny any claim during the first 2 years due to misstatement.

No claim for Critical Illness or Cancer that is diagnosed after 12 months from the Effective Date of this Policy will be reduced or denied on the ground that Critical Illness or Cancer not excluded on the date of loss by name or specific description, had existed before the Effective Date of this Policy.

Any increase in coverage, addition to coverage, or reinstatement of coverage, as requested by application from You, shall begin a new two-year contestable period for the amount of the increase, for the additional coverage, or for the reinstated coverage from the effective date of such increase, addition or reinstatement of coverage.

When We contest the validity of the coverage of this Policy, or any portion thereof, based on information given in the application for such coverage, We shall do so by a letter to You. This contest is effective on the date We mail the letter including the refund of any applicable Premium to You.

Misstatement of Age or Tobacco Usage

If the age of a Covered Person is misstated in the application, benefits will be those the Premium paid would have purchased at the correct age.

If the usage of tobacco is misstated for any Covered Person, coverage will be rescinded as of the Effective Date of coverage for that Covered person. Such rescission is subject to the provision entitled Statements in the Application.

Legal Actions

No legal action may be brought against Us within 60 days after written proof of loss has been sent to Us. No such action may be brought more than 2 years from the time written proof of loss is required to be given.

Unpaid Premium

On payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Conformity with State Laws

Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which You reside on that date, is change to conform to the minimum requirements of that state.

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SAMPLE

TRUSTMARK INSURANCE COMPANY

"We, Us, and Our"

400 Field Drive

Lake Forest, Illinois 60045-2581

(800) 918-8877

Medical Care Provider Referral Service Membership Endorsement

This Endorsement is made a part of the Certificate to which it is attached. Benefits provided by this Endorsement are subject to the terms and conditions of the Certificate, except as stated herein. This Endorsement is effective on the Effective Date.

Trustmark Insurance Company will provide a membership in a medical care provider referral service of Our choice to Covered Persons for a Critical Illness or Cancer covered under the Certificate.

Membership in the medical care provider referral service may permit Covered Persons access to the following:

A review of the Covered Person's medical file by a physician. The reviewing physician will provide a written report that confirms or redefines the Covered Person's diagnosis and identifies the treatment options; Identification of and referral to physicians who are suited to perform medical treatment for the Covered Person's condition; and Assistance with making appointments with medical providers and organizing details regarding medical treatment.

Additional services may be available under this membership. For specific details regarding additional services, contact the medical referral service directly.

The benefits provided by this Endorsement are intended only as a referral service. No medical advice is being offered by Us, nor are We endorsing the quality of any physician selected through this service. Utilization of this service is not required for benefits to be payable under the Certificate.

Termination of Endorsement and Vendor Changes. This Endorsement is optionally renewable by Us. We reserve the right to change the vendor of the medical care referral service, the services provided by the vendor or terminate this Endorsement, including the membership, at Our discretion at any time.

This Endorsement, including the membership, will terminate on the earliest of the following:

1. Termination of the Certificate to which this Endorsement is attached; or
2. Thirty (30) days after written notice of termination by Us has been sent to Your last known address.

TRUSTMARK INSURANCE COMPANY



Joseph L. Pray
President and Chief Executive Officer



Shea Welch
Corporate Secretary

**TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY OF NEW YORK
(We, Us, Our)**

NOTICE OF PRIVACY PRACTICES

Effective date of this notice: February 13, 2012

Our Commitment to Protecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You do not need to respond to this notice in any way.

Our Responsibilities and Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

Maintain the privacy of your personal information.

Provide you with certain rights with respect to your personal information.

Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information.

Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

Information We Collect

Personal Information is any information we obtain about you in the course of issuing insurance and/or providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical or mental health or condition, the provision of health care to you, payment for the provision of health care to you, your Social Security number, employment history, credit history, income information, and bank or credit card information.

We obtain this information from several sources, including but not limited to applications or other forms you complete, your business dealings with us and other companies, and consumer reporting agencies.

Our Privacy and Security Procedures

Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

Paper copies, when used, are viewed, discussed, and retained in private surroundings.

Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our insureds.

Our business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow our privacy procedures.

Information We Disclose

We will not disclose any Personal Information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes.

Underwriting;

Premium rating;

Submitting claims;

Reinsuring risk;

Assessing quality;

Business management and planning; and

Sales, transfer, merger or consolidation of the business.

Your information may also be shared:

For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.

With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.

In response to an administrative or judicial order, including a search warrant or subpoena.

With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.

To conduct actuarial or research studies. In this case, individuals are not identified in the research report. Material identifying an individual is destroyed as soon as it is no longer needed.

With our business associates for use in auditing services or operations, auditing marketing services, performing various functions on our behalf, or to provide certain services.

With a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.

To consult with outside health care providers, consultants and attorneys, and other health related services.

As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your Personal Information. We share only that which is minimally necessary to accomplish a task. Information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes.

Your written authorization is required for uses and disclosures of Personal Information for purposes other than those described above. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your Personal Information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Your Rights

Upon written request, you have the right to:

Inspect and copy certain Personal Information. We may charge a reasonable fee for the costs of copying or mailing.

Receive confidential communication of Personal Information.

Request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction.

Request an amendment to your Personal Information, although we are not required to agree to an amendment.

Receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with federal law (or state regulations, if applicable) for which an accounting is required.

Be notified of a breach of unsecured Personal Information.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

How to Contact Us

You may contact our representative at the following address:

Privacy Officer
Privacy Request
Trustmark Companies
PO Box 7961
Lake Forest, IL 60045-7961

Email - privacymanagementoffice@trustmarkins.com

Notification of a revised privacy notice will be provided through one of the following:

U.S. Postal Service
Revised Plan Document
Internet E-mail.

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by Trustmark Mutual Holding Company or its subsidiaries and affiliates.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2011)

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

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

Eligibility for Protection by the Association

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

Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**

Residents of other states, ONLY if the following conditions are met:

1. The policyholder has a policy with a company domiciled in Texas;
2. The policyholders state of residence has a similar guaranty association; and
3. The policyholder is not eligible for coverage by the guaranty association of the policyholders state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
(800) 252-3439 or www.tdi.state.tx.us

Trustmark
Voluntary Benefit Solutions®

A Division of Trustmark Insurance Company
B49CBTX3

New Voluntary Coverage Survey

Thank you for choosing Trustmark to provide your voluntary benefits! We value each and every one of our policyholders, and we are always looking for ways to improve the level of service you deserve. We would greatly appreciate it if you completed this short survey and returned it to us in the enclosed prepaid envelope. Should you have any questions regarding the survey, please contact us at (800) 229-4543 or email processmyapp@trustmarkins.com. Thank you in advance for your participation!

1. Is this the first time you were offered voluntary coverage? Yes No
2. Please select one or more reasons for your purchase.
 Estate planning
 Affordability
 Product design
 Ease of payroll deduction
 Re-enrollment
Other _____
3. How did you apply for your new policy?
 In-person enrollment
 Telephone
 Self-service kiosk
4. When did you receive your policy?
 1 to 3 weeks after enrollment
 4 to 6 weeks after enrollment
 7 to 12 weeks after enrollment
5. Were you satisfied with the time it took to receive your policy? Yes No
6. How likely are you to recommend Trustmark to a friend, family member or colleague?
NOT AT ALL LIKELY 0 1 2 3 4 5 6 7 8 9 10 VERY LIKELY
7. If we need to get in touch with you, how would you prefer to receive future communications?
 Phone _____
 Email _____
 Mail _____
8. Did the overall customer experience meet your expectations? Yes No

Optional:

If you answered no, please provide us with your contact information if you would like to discuss your experience.

Name (please print): _____ Telephone: _____

Email: _____ Best time to call: _____

9. Additional comments/feedback: