

CANCER: A disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, Hodgkin's Disease or Leukemia. Premalignant conditions, conditions with malignant potential or skin cancer other than malignant melanoma are not to be construed as Cancer in interpreting the policy.

WAITING PERIOD: Cancer first diagnosed during the 30 days following the Date of Policy will not be covered.

EXCEPTIONS AND LIMITATIONS: The policy provides benefits only for First Diagnosis of internal Cancer or malignant melanoma. No benefit is payable for the diagnosis of any other disease, sickness or incapacity.

PRE-EXISTING CONDITION LIMITATION: No benefit is payable for a Pre-Existing Condition for 24 months after the Date of Policy.

THIS IS A LIMITED BENEFIT CANCER INSURANCE POLICY: The brochure provides a brief description of Policy Form 70160 2/98. Policy provisions may vary by state. For complete information, please review the actual policy.

CASH RECEIPT

Received from _____
Name

the _____ day of _____,
Month Year

the sum of \$ _____ being the
payment of _____ month(s) premium. The insurance applied for shall not take effect until the Date of Policy, payment of the first premium and before any change in the applicant's insurability. In the event the application is declined, any payment made by the applicant will be returned.

Signature of Insurance Producer

Telephone Number of Insurance Producer

Make checks payable to **Kanawha Insurance Company**. Do not make payable to Insurance Producer or leave payee blank.

KMG AMERICA CORPORATION A STRONG HISTORY

KMG America Corporation (NYSE: KMA) is a leading provider of administrative services and insured products. Through Kanawha Insurance Company, its wholly-owned subsidiary, it offers working Americans a complete range of group and voluntary benefits and administrative solutions.

Kanawha Insurance Company was founded in 1958 for the best of reasons, to offer sound insurance solutions to employees. KMG America embraces this philosophy, and these principles remain a guiding force going forward.



800-451-9143



P.O. Box 610
Lancaster, SC 29721



CASH CANCER PLAN

Form 70160 2/98

*Pays a Lump Sum Cash Benefit
Immediately When First
Diagnosed with Cancer*

- ♦ 20-Year Paid Up Option
- ♦ Return of Premium Option
(Not approved in all states)



Why Cancer Insurance?

Consider these 2004 American Cancer Society statistics:

- 1 in 2 men and 1 in 3 women will get Cancer
- Cancer is the leading killer of children ages 1–14
- Cancer causes 1 of every 4 deaths
- 66% of costs to fight Cancer are non-medical indirect costs, not covered by traditional insurance



Indirect & Out-of-Pocket Costs You May Incur

Loss of Income

- Patient and caregiver

Insurance & HMO Shortfalls

- Deductibles & co-payments
- Scheduled benefit limitations
- Costs considered excessive
- Doctors, hospitals, cancer centers outside managed care program
- Treatments considered experimental

Loss of Assets

- Depleted savings*
- Real estate
- Personal property

Other Indirect Costs

- Home health care
- Transportation expenses to and from doctors and treatment facilities
- Food and lodging if treatment is out of town
- Child care

Normal Living Expenses

- Mortgage payments or rent
- Car payments
- Utility bills
- Groceries and household items
- Credit card payments

* 60% of families deplete savings (USA Today article)
Fact use does not imply endorsement.

Lump Sum Cash Benefits

- You receive a one-time lump sum cash payment, upon first diagnosis of internal Cancer or malignant melanoma;
- No hospitalization or treatment required to receive payment of cash benefit;
- Use the cash benefit for any purposes you choose;
- Pays in addition to other insurance you own;
- Under the Federal Internal Revenue Code, you may be able to exclude from income benefits you receive. Consult your tax advisor.

Plan Features

- **Benefit Choices:** \$10,000; \$20,000; \$25,000; \$30,000; \$40,000; \$50,000
- **Guaranteed Level Benefits:** Same lump sum amount for all covered family members, regardless of age.
- **Eligible Ages:** 0 to 69, use current age
- **Plan Types:**
 - Individual (Adult or child)
 - Family (2 parents and all children)
 - Single Parent (Parent and all children)
 (For 2 or more children only, use Single Parent)
- **Premium Payment Periods:**
 - Paid up after 20 years
 - Payable for life
- **Return of Premium Option:** If approved in your state, premiums will be refunded as shown if policy remains continuously in force and no claim has been paid.

Issue Age	End of Policy Year	Percentage Returned
0-64	20	100%
65-69	10	50%

- **Issue Age Premiums:** Premiums do not increase with advancing age.
- **Guaranteed Renewable:** Coverage is renewable for life if premiums are paid on time. Policy will terminate once claims have been paid for all covered persons.
- **Free Look Period:** Return policy within 30 days of receipt and all premiums refunded.
- **Easy to Apply:** No medical exam, no physician statements, no telephone interview... just complete the application.

MONTHLY PREMIUMS PER \$10,000 BENEFIT

Premium Calculations and Modal Factors

Benefit Amount:	\$10,000=As Shown	\$20,000=Monthly X 2
	\$25,000=Monthly X 2.5	\$30,000=Monthly X 3
	\$40,000=Monthly X 4	\$50,000=Monthly X 5

Modal Factors:	Annual=Monthly X 12
	Semi-Annual=Monthly X 6
	Quarterly=Monthly X 3

Minimum Bank Draft Amount: \$7 for monthly mode

Individual	Age	Life Pay	20 Pay	Life Pay + ROP	20 Pay + ROP
	0-24	\$4	\$5	\$5	\$6
	25-29	4	5	6	7
	30-34	5	6	7	8
	35-39	6	7	8	10
	40-44	8	9	10	12
	45-49	10	12	13	15
	50-54	13	15	17	19
	55-59	17	19	22	23
	60-64	21	23	28	29
	65-69	25	28	34	35

Family	Age	Life Pay	20 Pay	Life Pay + ROP	20 Pay + ROP
	0-24	\$7	\$9	\$9	\$11
	25-29	7	9	11	13
	30-34	9	11	13	15
	35-39	11	13	15	19
	40-44	14	16	18	22
	45-49	17	21	23	27
	50-54	23	27	31	35
	55-59	30	34	40	42
	60-64	37	41	51	53
	65-69	44	50	62	64

Single Parent	Age	Life Pay	20 Pay	Life Pay + ROP	20 Pay + ROP
	0-24	\$5	\$6	\$6	\$7
	25-29	5	6	7	8
	30-34	6	7	8	9
	35-39	7	8	9	11
	40-44	9	10	11	13
	45-49	11	13	14	16
	50-54	14	16	18	20
	55-59	18	20	23	24
	60-64	22	24	29	30
	65-69	26	29	35	36

**APPLICATION FOR
FIRST DIAGNOSIS CANCER
APPLICATION NUMBER**

KANAWHA
INSURANCE COMPANY

210 South White Street, P O Box 610
Lancaster, South Carolina 29721-0610

HOME OFFICE USE ONLY
POLICY NUMBER:
POLICY DATE:

PERSONS PROPOSED FOR COVERAGE (Print)	SEX	BIRTHDATE	AGE	SOCIAL SECURITY NUMBER
Proposed Insured's Name (First Name, MI, Last Name)				
Spouse				
Child 1				PLAN TYPE <input type="checkbox"/> Individual (adult or child) <input type="checkbox"/> Family (2 parents and all children) <input type="checkbox"/> Single Parent (parent and all children) <input type="checkbox"/> Children only (use single parent rate)
Child 2				
Child 3				
Child 4				

PROPOSED INSURED'S INFORMATION

Address		
City	State	Zip Code
Within City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone ()	Work Phone ()	

PAYOR INFORMATION (if different from Proposed Insured)

Name		
Address		
City	State	Zip Code
Within City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SAMPLE
DO NOT USE

PROPOSED INSURED'S EMPLOYER & DATE OF EMPLOYMENT

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BILLING INFORMATION

Mode Premium \$	Requested Effective Date: Month Day Year
Payment Method:	
<input type="checkbox"/> List Bill Group #	<input type="checkbox"/> Direct Bill <input type="checkbox"/> Bank Draft
Payment Mode:	
<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly (Bank Draft or List Bill Only) <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
Mail Policy To:	
<input type="checkbox"/> Agent	<input type="checkbox"/> Insured <input type="checkbox"/> Employer

BENEFIT SELECTION

<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$40,000	Return of Premium: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$50,000	
Premium Payment Period:			
<input type="checkbox"/> Payment for 20 Years		<input type="checkbox"/> Continuous Payment for Life	

CURRENT INSURANCE

Will this policy replace any existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", list company name, Insured, and policy number.

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

I hereby represent to Kanawha Insurance Company to the best of my knowledge, information and belief:

- No person to be insured under this policy has now or ever been medically diagnosed as having or been treated by a physician for internal cancer, melanoma, leukemia, Hodgkin's Disease, malignant growth, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or tested positive for the Human Immunodeficiency Virus (HIV) except _____ who is/are to be excluded from coverage under this policy. (write "none", if none)
- I agree the policy will not be effective until it has actually been issued and received; and understand no benefits are payable for a diagnosis of cancer in the first 30 days after the policy effective date.
- I understand any person who, with intent to defraud or knowing he/she is facilitating a fraud against any insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signed at _____ Date _____ X
City and State Proposed Insured's Signature (Parent or Guardian if child(ren) only coverage)

AGENT'S CERTIFICATION

I certify any information recorded by me on this application is true and accurate to the best of my knowledge and belief.

I have received from _____ this _____ day of _____ the sum of \$ _____ being the payment of _____ month(s) premium. (Name) (Month) (Year)

Will this insurance replace any existing coverage? Yes No Check here if Proposed Insured(s) are agent's immediate family.

Agent's Signature _____ Date _____

Agent #	Print Agent's Name	Agent #	Print Agent's Name
Comm. % Split	Agent's Phone ()	State License No.	Comm. % Split Agent's Phone () State License No.

COMPLETE ONLY IF PAYMENT IS TO BE MADE BY BANK DRAFT

AUTHORIZATION FOR PREAUTHORIZED DEBITS

KANAWHA INSURANCE COMPANY, P. O. BOX 610, LANCASTER, SC 29721-0610
(800) 635-4252, EXTENSION 2518

Name of Depositor (Print) _____

Bank Name and Address _____

Policy Number _____

As a convenience to me, I request and authorize KANAWHA INSURANCE COMPANY to make deductions from my bank account for payment of premiums.

1. Each debit shall constitute proper notice of premium due and will be made on the day of policy.
2. If the Authorization pertains to coverage on a pending application, this agreement shall not become effective unless and until the coverage is issued and delivered.
3. This Authorization shall not be construed as modifying any provisions of the coverage.
4. Kanawha shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the policy for payment shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions.
5. The Authorization may be discontinued by Kanawha or by the Undersigned at any time within five (5) business days prior to the debit date. Upon termination of this authorization, the premiums on the policy covered will be payable quarterly as provided by the provisions.
6. Kanawha will notify you ten (10) days prior to any changes in payment amounts.

- Checking Renewal premiums will be debited on MONTHLY mode unless a different mode is checked below:
- Savings Quarterly Semiannually Annually

Draft Deposit Date _____ (29, 30, and 31 of month not available)

Signature of Depositor: _____ Date: _____

(A deposit slip or voided check for account and routing number verification is required.)

**SAVE . . .
TIME & MONEY**

Pre-authorized Bank Check Plan or Electronic Transfer are the convenient ways to pay insurance premiums. Payments on time, for correct amount . . . no unintentional lapse of protection. You have no checks to make out. No postage stamps to bother with. No premium notices to return.

A Voided Check and Signed Authorization are Required for Each Application.

COMPLETE ONLY IF PAYMENT IS TO BE MADE BY PAYROLL DEDUCTION

Kanawha Insurance Company

PAYROLL DEDUCTION AUTHORIZATION

SS#/ID# _____

Name of Employee

Policy Number(s)

Name of Employer

Group Number

The amount of deduction for this policy(ies) is \$ _____ per pay period.

Monthly S-Monthly Bi-Weekly, effective _____

I authorize the above deduction be made from my wages and the total amount deducted for premium be remitted to Kanawha Insurance Company. In the event of a change in pay period, my employer is authorized to adjust the deduction so a comparable amount will be deducted. My employer is authorized to double the amount in order to collect past due premiums. My employer is authorized to adjust deductions as listed in "Home Office Amendments" based on my request(s) to Kanawha Insurance Company and/or the terms of my policy.

It is understood that this deduction and remittance shall cease (1) upon termination of my employment, or (2) upon my written notice to my employer of the cancellation of this request, or (3) upon termination of the salary deduction agreement between Kanawha Insurance Company and my employer.

HOME OFFICE AMENDMENTS: Change the deduction for this policy(ies) to \$ _____ per pay period as shown above.
Date: _____ Initial: _____

Signature of the Employee

Date