



APPLICATION FOR THE CANCER EXPENSE POLICY



TO: ZURICH INSURANCE COMPANY — Chicago, Illinois 60604

POLICY NUMBER... 5002389

Do Not Complete Above This Line

EFFECTIVE DATE

DEC 2 1975

NAME OF APPLICANT (Please print clearly with ball point pen)

SEX... F... AGE... 76...

Crabell

(Last)

Mabel

(First)

Marie

(Middle)

DATE OF BIRTH... 7... 1... 99

(Mo.) (Day) (Yr.)

STREET ADDRESS... 1927 E. 17th

PHONE 288-9410

CITY AND STATE... Muncie Ind.

ZIP CODE...

FOR MEMBERS OF:

HOOSIER MOTOR CLUB

SIX MONTHS PREMIUM ▶

☒ Individual Plan... \$15.00☐ Family Plan... \$22.50

AGREEMENT AND REPRESENTATION OF APPLICANT: I, hereby, represent that, to the best of my knowledge, information and belief, no person to be insured under this Cancer Expense Policy has now, or ever has had, any type of cancer in any form,

EXCEPT... who is to be completely excluded from all coverage of this policy

(IF FAMILY PLAN ONLY THE NAME OF PERSON THAT HAS OR EVER HAD CANCER)

Agent's Signature

No. 1053

Applicant's Signature

FORM 8543

MAKE CHECKS PAYABLE TO — ZURICH INSURANCE COMPANY

Acc 00016908

THIS POLICY PROVIDES BENEFITS FOR HOSPITAL SERVICES AND OTHER
EXPENSES CAUSED BY CANCER TO THE EXTENT HEREIN PROVIDED

Zurich Insurance Company

EXECUTIVE OFFICES, CHICAGO, ILLINOIS

(A Stock Company, Herein Called The Company)



Policy Number 5002389

IN CONSIDERATION of payment of the premium set forth in the Application (which is attached hereto and made a part of this policy), HEREBY INSURES the insured as defined under the provisions of this policy, to the extent herein provided, against loss resulting from hospital confinement and other specified expenses (in accordance with the provisions and conditions and subject to the exceptions and limitations stated in this policy), incurred for the definitive treatment of the disease "cancer" as hereinafter defined, only (hereinafter called "such sickness"), providing such cancer is positively diagnosed in accord with the standard hereinafter set forth.

OPTION TO SURRENDER WITHIN TEN DAYS

This policy may be returned by the insured to any agent or to the Executive Offices of the Company within ten days of its delivery date for a complete refund of premium and cancellation of policy without cause.

IMPORTANT NOTICE: Please read the copy of the application attached to this policy. Carefully check the application and write to the Company within 10 days, if any information shown on it is not correct and complete. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

THE PROVISIONS on the following pages are part of this policy.

IN WITNESS WHEREOF, The Zurich Insurance Company has caused this policy to be signed by its United States Manager at Chicago, Illinois.


United States Manager (Zurich)
President (American Guarantee)

PRIVILEGE OF RENEWAL—THIS POLICY IS RENEWABLE AT THE OPTION OF THE INSURED AT SUCH PREMIUM RATES THAT SHALL BE IN EFFECT ON THE DATE OF EACH RENEWAL. PREMIUM CHANGEABLE BY THE COMPANY ON ALL PLANS BEARING THIS FORM NUMBER AND NOT ON AN INDIVIDUAL POLICY BASIS.

Part 1

A. INSURED DEFINED: If this is an individual policy, the term "insured" whenever used in this policy shall mean the applicant named in the Application. If this policy is issued as a Family Plan, such Family Plan is defined as the named insured, the spouse of the named insured and all dependent children of the named insured unmarried and under 21 years of age. The insurance on any child covered under the terms hereof shall terminate on the anniversary date of this policy next succeeding such child's marriage or twentieth birthday, whichever first occurs, but such termination shall be without prejudice to any claim originating prior thereto. The acceptance of premium by the Company after such date, or dates, shall be considered as premium for only the remaining persons who qualify as insured under the general provisions of the policy. Provided further that coverage of any such Family Plan shall include any other unmarried dependent child up to age 23 so long as such unmarried dependent child is and remains a full time student in a licensed school or college. Notwithstanding the foregoing provisions respecting termination of insurance of a dependent person due to his attainment of the limiting age, a dependent person who is both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the named insured for support and maintenance on the date he would otherwise cease to be covered under this policy solely due to his attainment of the limiting age shall continue to be covered hereunder during the continuance of such incapacity and dependency but only while this policy continues in force according to its terms, and subject to all other provisions of this policy.

B. HOSPITAL DEFINED: Whenever used in this policy, the word "hospital" shall mean a legally operated institution which: maintains and regularly uses on its premises a laboratory, x-ray equipment and operating room where surgical operations may be performed; maintains permanent and fulltime facilities for the care of overnight resident bed patients under the supervision of a licensed physician; provides 24-hours-a-day nursing service by graduate Registered Nurses; and maintains on the premises the patient's written history and medical records. The word "hospital" shall not include any facility contracted for or operated by the United States Government for the treatment of members or ex-members of the armed forces, unless the insured individuals would be required to pay such charges in the absence of insurance; and shall not include any institution or part thereof used, other than incidentally, as a place for rehabilitation, rest, the aged, drug addicts or alcoholics, a mental institution, sanitarium, nursing or convalescent home, a long term nursing unit or geriatrics ward, or as an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Part 2

CANCER DEFINED—POSITIVE PATHOLOGY REQUIRED

A. Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or Leukemia.

Such cancer as above defined must be positively so diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy or by an Osteopathic Pathologist, upon the basis of a microscopic examination of fixed tissue, or preparations from the hemic system (either during the life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

B. Whenever the insured is provisionally diagnosed as a cancer victim and thereafter receives definitive treatment or hospital care as a result thereof and positive diagnosis is impossible during life, then in that event the Company will pay its liability under the policy upon positive diagnosis post mortem by a legally qualified pathologist as in the policy set forth beginning with the date of provisional diagnosis.

Part 3

BENEFITS FOR SUCH SICKNESS

A. If any insured shall become afflicted with cancer, as herein defined, which is first diagnosed as provided herein on or after the 30th day following the Date of Policy shown in the Application and while this policy is in force, provided such insured has never had any cancer diagnosed prior to such 30th day, the Company will pay indemnities according to the Schedule of Benefits, Part 4, and Extended Benefits, Part 3-B, for the expenses incurred by the insured, except as otherwise provided herein, for the definitive treatment of cancer positively diagnosed as herein provided, beginning with the day such diagnosis is made or ten days prior to the date of such diagnosis, whichever is most favorable to the insured, but in no case shall more than the maximum benefits shown in the Schedule of Benefits, Part 4, and Extended Benefits, Part 3-B, for each service or benefit be paid with respect to any one insured, irrespective of the number of cancers or malignant tumors experienced by said insured. If for the first time in the entire lifetime of the insured cancer is first diagnosed on or after the 30th day following the Date of Policy shown in the Application, the Company may not deny a claim for such loss on the grounds that the illness existed prior to the effective date of coverage in this policy. Nothing herein shall, however, be construed to limit in any way the rights of the insured under Part 7, Sub-section 2, entitled "Time Limit on Certain Defenses."

B. EXTENDED BENEFITS: During any period of hospitalization when any insured is confined to a hospital for less than 90 consecutive days for the definitive treatment of cancer, indemnities will be paid according to the Schedule of Benefits, Part 4.

If any insured shall be continuously confined to a hospital for an uninterrupted period exceeding 90 consecutive days for the definitive treatment of cancer, then on and after the 91st day of such continuous hospital confinement and until the termination of such period of continuous hospital confinement, in lieu of benefits under the Schedule of Benefits, Part 4, the Company will pay 100% of the usual and customary charges actually made by the hospital for such care and treatment on and after such 91st day, without any deduction for prior benefits paid; provided, that during such extended benefit period the Company's liability shall be limited to \$5,000.00 per month (30 days to be considered a month, with periods of less than 30 days limited proportionately). Benefits for subsequent periods of hospitalization of less than 90 consecutive days will be paid under the Schedule of Benefits, Part 4, subject to the limitations contained therein.

C. MAXIMUM BENEFITS PER PERSON — \$60,000.00: The sum total of all benefits under this policy shall not exceed \$60,000.00 per person.

Part 4

SCHEDULE OF BENEFITS FOR SUCH SICKNESS

As provided in Part 3-A hereof (Benefits for Such Sickness) the Company will pay indemnities according to the following Schedule of Benefits (maximum benefit amounts shown are for the entire lifetime of each insured):

A. HOSPITAL CONFINEMENT BENEFIT: The Company will pay Sixty (\$60.00) Dollars per day for each of the first seven (7) days of each period of hospital confinement and Thirty (\$30.00) Dollars for each day thereafter. EXCEPTION: If less than thirty (30) days separates two periods of hospital confinement, then for purposes of calculating hospital confinement benefits under this section, such period of hospital confinement shall be considered to be a continuation of the prior period of hospital confinement.

B. DRUGS AND MEDICINE: The Company will pay the actual charges made by the hospital for drugs and medicines administered while confined to the hospital, not to exceed 10% of the Hospital Confinement Benefit payable under item A (Part 4) above, for each claim.

C. AMBULANCE BENEFIT — MAXIMUM BENEFIT \$500.00: The Company will pay the usual and customary charges made by a licensed ambulance company for transporting the insured to or from the hospital in which the insured is admitted as a patient, not to exceed \$50.00 for each confinement.

D. ATTENDING PHYSICIAN BENEFIT — MAXIMUM BENEFIT \$600.00: If the insured, as the result of such sickness, shall require the services of a licensed physician, other than or in addition to the surgeon who performed surgery, the Company will pay the actual charge not to exceed Ten (\$10.00) Dollars per day for such doctor's visits to the insured while confined to the hospital. Not more than one doctor's visit per day will be allowed and the term "visit" shall mean an actual personal call by the doctor.

E. BENEFITS FOR NURSING SERVICES — MAXIMUM BENEFIT \$600.00: The Company will pay up to Twenty-Four (\$24.00) Dollars per day for nursing services on behalf of any insured hereunder who received full time and private care and attendance (other than that regularly furnished by the hospital) for registered graduate nurses or registered licensed practical nurses not related to the insured, when required and authorized by the attending physician in treatment of such sickness when confined to the hospital.

F. X-RAY RADIUM AND COBALT THERAPY BENEFIT — MAXIMUM BENEFIT \$1,000.00: The Company will pay the usual and customary charges for such treatment. This provision shall not be construed to include diagnostic x-ray or other diagnostic procedures or laboratory tests related to these treatments.

G. ANESTHESIA: The Company will pay actual charges not to exceed \$70.00 per operation for either (a) the professional fee of an Anesthesiologist not employed by the hospital or (b) charges made by the hospital where anesthesia is administered by an Anesthetist employed by the hospital. This fee limited to \$30.00 for skin cancer operations.

H. BLOOD AND PLASMA BENEFIT — MAXIMUM BENEFIT \$300.00: The Company will pay the usual and customary charge for blood and plasma.

I. SURGICAL BENEFIT: When a surgical operation for the treatment of cancer is actually performed on the insured for a condition which has been diagnosed, as provided for on Page 2, as being cancer, the Company will pay the fee for such operation, including post-operative attendance, not to exceed the amount set opposite the name of the operation in the Schedule of Operations. If any operation for the treatment of cancer is performed other than those listed, the Company shall pay a comparably reasonable fee for such operation, but in no case shall such fee exceed \$500.00. Two or more surgical procedures performed through the same abdominal incision will be considered as one operation.

SCHEDULE OF OPERATIONS

	Maximum Amount		Maximum Amount		Maximum Amount
ABDOMEN		AMPUTATIONS		GENITO-URINARY TRACT	
Complete resection of the stomach	\$400.00	Thigh, leg, or entire foot ..	\$300.00	Removal of kidney	\$400.00
Partial resection of the stomach	\$300.00	Arm, forearm, or entire hand	\$300.00	Removal of prostate, com- plete procedure	\$400.00
Resection of the small bowel	\$500.00	Fingers or toes only, each ..	\$ 50.00	Removal of uterus, tubes and ovaries	\$400.00
Resection of the ascending or transverse colon	\$300.00	BRAIN		MOUTH	
Combined abdominal peri- neal resection or cancer of the rectum or sigmoid	\$400.00	Exploratory Craniotomy ...	\$200.00	Cutting operation for re- moval from:	
Colostomy or ileostomy ...	\$200.00	Complete removal of cancer of brain	\$500.00	Mouth, tongue, tonsil, mu- cous membrane of the mouth	\$200.00
Resection of esophagus ...	\$500.00	BREAST		NECK	
Gastronomy done in connec- tion with esophagus	\$200.00	Amputation of one breast ..	\$200.00	Complete resection of glands of the neck	\$400.00
Splenectomy	\$300.00	Amputation of both breasts	\$300.00	RECTUM	
Complete cystectomy with urethral transplant	\$500.00	CHEST		Proctectomy	\$200.00
Simple excision of the bladder	\$200.00	Exploratory thoracoplasty to establish the cancer	\$200.00	SKIN	
EYE		Complete lobectomy	\$400.00	Cutting operation for re- moval from skin	\$ 50.00
Enucleation with complete resection	\$200.00	EXTERNAL GENITALIA		SPINAL	
		Women		Operation with removal of portion of vertebra or ver- tebrae	\$400.00
		Complete excision for re- moval of the vulva or va- gina with regional lymph nodes	\$300.00	THROAT	
		Cauterization of the cervix ..	\$ 50.00	Excision of larynx	\$200.00
		Men		Thyroidectomy	\$150.00
		Cancer of penis—complete excision of regional lymph nodes	\$300.00	Thyroid and radical com- plete removal of Thyroid gland (Goitre)	\$300.00
		Orchiectomy—i.e., removal of testicles	\$200.00		

Part 5

MAXIMUM COVERAGE

The Company's liability on this cancer plan when taken together with all other cancer policies on whatever form number or plan which may have heretofore been or may hereafter be issued by the Company shall be limited on any covered expense to the benefits indemnifiable and payable under this policy on any one claim and all excess premiums which have been paid by the insured for such excess coverage shall be refunded proportionately in full.

Part 6

EXCEPTIONS AND LIMITATIONS

This policy pays only for loss resulting from definitive cancer treatment, including only direct extension, metastatic spread, (and/or its direct effects) or recurrence. This policy does not cover any other disease or sickness or incapacity.

Part 7

UNIFORM PROVISIONS

- 1. ENTIRE CONTRACT; CHANGES:** This policy, including a copy of the application for same, the endorsements and the attached papers, if any, constitute the entire contract of insurance. No change in the policy shall be valid until approved by an executive officer of the Insurance Company and unless such approval signed by the insured be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.
- 2. TIME LIMIT ON CERTAIN DEFENSES:** (A) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.
(B) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.
- 3. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

- 4. REINSTATEMENT:** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt, unless the Company has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such sickness as may begin more than ten days after date of reinstatement. In all other respect the insured and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.
- 5. NOTICE OF CLAIM:** Written notice of claim must be given to the Company within sixty days after the occurrence of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the Beneficiary to the Company at Chicago, Illinois or to any authorized agent of the Company, with information sufficient to identify the insured, shall be deemed notice to the Company.
- 6. CLAIM FORMS:** The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
- 7. PROOFS OF LOSS:** Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
- 8. TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid each 4 weeks, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
- 9. PAYMENT OF CLAIMS:** All indemnities will be payable to the insured. Any accrued indemnities unpaid at the insured's death may at the option of the insured be paid to any assignee or to the estate of the insured.
- 10. PHYSICAL EXAMINATION:** The Company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.
- 11. LEGAL ACTIONS:** No action at law or in equity shall be brought to recovery on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
- 12. CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.
- 13. CONSIDERATION CLAUSE:** This policy is issued in consideration of payment of the initial premiums and solely upon information furnished in the application, which is part of the policy, and the Company may rely upon the answers furnished to be true and correct.
- 14. RENEWAL-NOTICE OF CHANGE IN PREMIUM:** This policy is renewable at the option of the insured for the entire lifetime of the insured but each renewal shall be at the established standard premium rate for such policy on the date of each renewal. In the event of a change in the established standard premium rate, the Company shall notify the insured in writing at his last known address of such change at least thirty (30) days before the due date, at which time such change is to become effective. The Company may change premiums, on all plans bearing this form number, by plan only, and not by age, sex or health condition. Premium changes only on date of renewal.
- 15. TERM-EFFECTIVE DATE:** The term of this policy begins on the Policy Date at 12:00 o'clock, noon, Standard Time, of the place where the insured then resides and ends at 12:00 o'clock, noon, the same Standard Time, on the first Renewal Date. Each renewal term ends at 12:00 o'clock, noon, the same Standard Time, on the date the new renewal premium is due.

ATTACH COPY OF APPLICATION HERE

THIS IS A LIMITED POLICY
READ IT CAREFULLY