

EXHIBIT 1

AFFIDAVIT OF ROBERT HEISSE

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

I, Robert Heisse, being duly sworn, hereby depose and aver as follows:

1. I am employed as a Fraud Investigator by the Insurance Division of the Department of Commerce and Insurance of the State of Tennessee (“Division”) and have served in that capacity for approximately four years. In my position with the Division, I am responsible for investigating certain matters assigned to me. I also maintain the custody of documents obtained by the Division for the investigations that I have been assigned. I have been employed with the State of Tennessee since 1995. Before working as a Fraud Investigator for the Insurance Division, I was a Credit Union Examiner for the Department of Financial Institutions from December 2004 to March 2006. I was an investigator for the Securities Division of the Department of Commerce and Insurance for approximately six years from January 1998 to December 2004 and an examiner for the Registration Section of the Securities Division for approximately three years. I hold a Bachelor of Science degree in Public Administration and a Master of Business Administration degree from the University of Tennessee at Martin. I have had extensive training in financial investigations from the National White Collar Crime Center. In 2005, I successfully completed the new examiner training program conducted by the National Credit Union Administration. Also, I am a Certified Fraud Examiner and member of the Association of Certified Fraud Examiners. I am currently the investigator assigned to the matter of American Trade Association, LLC (ATA LLC), American Trade Association, Inc. (“ATA”), Smart Data Solutions, LLC (“SDS”), Serve America

Assurance (“SAA”), Bart Posey (“Posey”) and others. All of the knowledge I have obtained about the activities of ATA LLC, ATA, SAA, and SDS and the persons and entities affiliated with those entities have been obtained over the course of my investigation.

2. In or around October 2008, I was assigned to this matter to investigate ATA LLC, ATA, SDS, and Posey for potential violations of Tennessee insurance law.

3. Since that time, I have interviewed individuals involved. I have collected and examined contracts, sales materials, the different ATA LLC and ATA websites, and other documents. On March 24, 2009, a subpoena duces tecum was issued for certain records and documents within their possession. Some of these documents were obtained from Posey.

4. On or about November 22, 2005, Posey incorporated SDS in the State of Tennessee as a limited liability company (Secretary of State I.D. Number 000507138). A certified copy of the corporate charter for SDS is attached hereto as **Exhibit A**.

5. American Trade Association, LLC is a business entity incorporated in the State of Arkansas on or about February 28, 2008 with a business address of 4676 Highway 41 North, Springfield, TN 37172.

6. American Trade Association, Inc. is a business entity with the address of 4676 Highway 41 North, Springfield, TN 37172. American Trade Association, Inc. was incorporated in the state of Indiana. ATA was incorporated in the State of Tennessee as a foreign corporation on or about May 15, 2009.

7. Based on my review of the corporate records, Bart S. Posey controls ATA and ATA LLC. Obed Kirkpatrick, Sr. is the President of ATA. Richard H. Bachman is

the Vice President of ATA. Both Obed Kirkpatrick, Sr. and Richard Bachmann are employed by Posey in some capacity. ATA LLC is owned by Posey.

8. From the documents I have reviewed and witnesses I have interviewed, ATA, ATA LLC, SDS and Posey have been responsible for selling purported health insurance to individuals throughout the United States including individuals in the State of Tennessee. ATA, ATA LLC, SDS and Posey have also acted as an unlicensed insurance company throughout the United States and in the State of Tennessee.

9. On or around July 2008, Posey began marketing and selling several limited benefit health plans in this state through ATA LLC in conjunction with Real Benefits Association (“RBA”), a New Jersey entity, utilizing the internet sites <http://rba-ata.com>, <https://atafirst.com/> and <http://www.healthenroll.net/> and other means in this State.

10. On or around January 2009, Posey, SDS and ATA LLC, through this website, <http://rba-ata.com/>, offered the Limited Medical Plan (“Limited Medical Plan”), the Per Occurrence Plans (“Per Occurrence Plans”) and the Critical Illness Plan (“Critical Illness Plan”) purportedly underwritten by Serve America Assurance, LTD (“SAA”). Copies of the Master policy and certificates of coverage issued under the master policy are attached hereto as **Exhibit B**.

11. On or before March 2009, Posey, SDS and ATA LLC began marketing and selling the Limited Medical Plan, the Per Occurrence Plan and the Critical Illness Plan through various internet sites including, but not limited to, www.premierhealthcareonline.com, www.myatabenefit.com, www.prosperitypreparedness.com, www.healthtoday.biz,

www.pinnaclehealthsavings.com and www.ehealthgreen.com, and other means in this State.

12. As of February 25, 2010, the last date on which I viewed the web site, Posey, SDS, ATA LLC, and ATA continue to sell, solicit and negotiate insurance in Tennessee through the internet website

<http://www.myatabenefits.com/index.php/index.php>.

13. Posey, SDS, ATA LLC and ATA utilize the internet and marketing companies to solicit business. The marketing companies are paid a portion of the membership fee and premiums. Based on records I obtained during the course of my investigation, it appears that the marketers utilize unsolicited faxes sent by automated dialers, the internet, mailers, and telemarketing. The target market is small businesses, people who cannot obtain insurance due to a pre-existing condition, and anyone who cannot afford a major medical policy.

14. On or around July 2008, SDS began administering several limited benefit health plans in this state allegedly underwritten by SAA. SDS has and continues to prepare and distribute insurance cards and fulfillment packages to enrollees of ATA LLC and ATA for this purported health insurance coverage. SDS has collected premiums for the purported health insurance provided from the enrollees of ATA LLC and ATA.

15. I have interviewed approximately 10 people who have purchased coverage from Posey, SDS, ATA LLC and ATA, paid premiums to Posey, SDS, ATA LLC, and ATA, and who have failed to have their claims paid when they were submitted to Posey, SDS, ATA LLC and ATA.

16. On February 4, 2010, I interviewed Durenda Hood. Ms. Hood is a 59 year old Tennessee resident who purchased health insurance through Posey, SDS, ATA LLC and ATA. On October 9, 2008, Ms. Hood had \$336.00 deducted from her checking account and has had \$211.00 per month deducted from her checking account since then to pay for the ATA health insurance premium. The total she paid for the health insurance was \$3,290.00. As of February 2010, Ms. Hood stated she continued to have the \$211.00 per month premium deducted from her checking account. A copy of Ms. Hood's affidavit is attached as **Exhibit C**.

17. On March 7, 2010, I interviewed Paul Brooks. Mr. Brooks is a Tennessee resident who purchased health insurance through Posey, SDS, ATA LLC and ATA. In June 2009, he began paying \$445.00 a month in premium. From June 2009 through November 2009, Mr. Brooks paid about \$2,700.00 in premiums to Posey, SDS ATA LLC and ATA. Mr. Brooks has approximately \$3,000.00 in unpaid claims. At the end of November 2009, Mr. Brooks cancelled the ATA health insurance. A copy of Mr. Brooks's affidavit is attached as **Exhibit D**.

18. On February 24, 2010, I interviewed Max Fagan who resides in Pleasant View, Tennessee. On or about August 2009, he purchased health insurance offered by the Posey, SDS, ATA LLC and ATA for his family after his wife spoke with Angie Posey. He pays \$506.00 a month. Mr. Fagan has approximately \$8,000 in unpaid claims. The most recent payment he has made was in February 2010. Recently, Mr. Fagan said the discount prescription plan has been terminated. He was told by SDS they would cover any prescription costs until the plan was reinstated. A copy of Mr. Fagan's affidavit is attached as **Exhibit E**.

19. Based on loan documents I have reviewed, it appears that Posey has used premium money collected from his customers on personal expenses and expenses not related to the operation of an administrator or an insurance company. Specifically, I identified a check (#2521), that Posey issued on December 23, 2009 from his SDS checking account (account # ****0201) in the amount of \$588,539.78 to First State Bank. This check paid off a mortgage loan held at First State Bank. The mortgage loan was secured by property located at 4676 Highway 41 North in Springfield, Tennessee.

Exhibit F.

20. Based on my review of property tax assessor's records and the registrar of deeds, this property is owned individually by Posey.

21. Several state insurance regulators have issued Cease and Desist Orders against one or more Posey related entities including Missouri, Connecticut, Arkansas, Indiana, Delaware, Michigan, Montana, North Carolina and Oklahoma. In each of these states, Posey, SDS, ATA LLC and ATA collected premiums for offering purported health insurance coverage and failed to pay claims. Certified copies of the Oklahoma, Arkansas, Kansas, Montana, and Michigan orders are attached as **Exhibit G.**

22. On March 3, 2010, I received a certified copy of a complaint file in the Chancery court for Robertson County, Tennessee. In the complaint, ATA files suit against William Worthy, II, South East Insurance Advisors, LLC and Nationwide Administrators, LLC alleging that Serve America Assurance, LTD is a fictitious company and that the defendants stole \$2,000,000 from ATA by fraudulently collecting money from ATA on behalf of Serve America Assurance, LTD. **Exhibit H.**

23. Based on the information I have collected and reviewed, Posey, SDS, ATA LLC, ATA, and their representatives have sold and marketed unlicensed health insurance in the State of Tennessee, have operated an unlicensed administrator in the State of Tennessee, and have operated an unlicensed insurance company in the State of Tennessee.

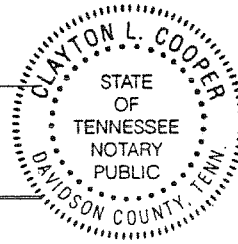
FURTHER AFFIANT SAITH NOT.

Robert Heisse
Robert Heisse

* SWORN TO AND SUBSCRIBED before me on this 18TH day of March, 2010.

Clayton L. Cooper
Notary Public

My Commission Expires: _____



My Commission Expires JULY 5, 2011



Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

ISSUANCE DATE: 09/04/2008
 REQUEST NUMBER: 08248517

CHARTER/QUALIFICATION DATE: 11/22/2005
 STATUS: ACTIVE
 CORPORATE EXPIRATION DATE: PERPETUAL
 CONTROL NUMBER: 0507138
 JURISDICTION: TENNESSEE

TO:
 ROBERT HEISE/COMMERCE & INSURANCE
 500 JAMES ROBT PKWY
 4TH FLOOR DCT
 NASHVILLE, TN 37243

REQUESTED BY:
 ROBERT HEISE/COMMERCE & INSURANCE
 500 JAMES ROBT PKWY
 4TH FLOOR DCT
 NASHVILLE, TN 37243

I, RILEY C DARNELL, SECRETARY OF STATE OF THE STATE OF TENNESSEE DO HEREBY CERTIFY THAT

 "SMART DATA SOLUTIONS LLC"

WAS INCORPORATED OR QUALIFIED TO DO BUSINESS IN THE STATE OF TENNESSEE ON THE
 ABOVE DATE, AND THAT THE ATTACHED DOCUMENT(S) WAS/WERE FILED IN OFFICE ON THE
 DATE(S) AS BELOW INDICATED:

REFERENCE NUMBER	DATE FILED	FILING TYPE	FILING ACTION																	
			NAM	DUR	STK	PRN	OFC	AGT	INC	MAL	FYC									
5614-1042	11/22/2005	LLC ORGANIZATIO																		
6044-1419	04/01/2006	AN RPT																		
ROLL 5809	06/14/2006	LLC NOTICE/DET																		
ROLL 5835	08/21/2006	LLC ADMIN/DISS																		
6044-1431	04/01/2007	AN RPT																		
6044-1423	04/26/2007	LLC REINST ORG																		
6050-0385	05/02/2007	LLC CERT REINST																		
6364-1120	04/01/2008	AN RPT																		
ROLL 6325	06/17/2008	LLC NOTICE/DET																		

FOR: REQUEST FOR COPIES

ON DATE:

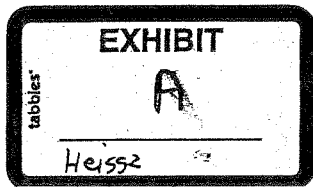
FEEs

FROM:

RECEIVED: \$0.00 \$0.00

TOTAL PAYMENT RECEIVED: \$0.00

RECEIPT NUMBER:
 ACCOUNT NUMBER:



Riley C Darnell

RILEY C. DARNELL
 SECRETARY OF STATE

State of Tennessee



Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

ARTICLES OF ORGANIZATION
(LIMITED LIABILITY COMPANY)

(Do not use if formed on or after January 1, 2006, under TN Revised LLC Act)

For Office Use Only

RECEIVED
TENNESSEE

2005 NOV 22 AM 9:26

SECRETARY OF STATE

The undersigned acting as organizer(s) of a Limited Liability Company under the provisions of the Tennessee Limited Liability Company Act, § 48-205-101, adopts the following Articles of Organization.

1. The name of the Limited Liability Company is:

SMART DATA SOLUTIONS LLC

(NOTE: Pursuant to the provisions of § 48-207-101, each limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:

BART POSEY

(Name)

4676 HIGHWAY 41 NORTH SPRINGFIELD TN 37172

(Street Address)

(City)

(State/Zip Code)

ROBERTSON

(County)

3. List the name and complete address of each organizer of this Limited Liability Company.

BART POSEY

(Name)

3448 FOREST PARK SPRINGFIELD TN

(Include: Street Address, City, State and Zip Code)

(Name)

(Street Address, City, State and Zip Code)

(Name)

(Street Address, City, State and Zip Code)

4. The Limited Liability Company will be: (NOTE: PLEASE MARK APPLICABLE BOX)

Board Managed Member Managed

5. Number of members at the date of filing 3

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is:

Date _____, Time _____ (Not to exceed 90 days.)

7. The complete address of the Limited Liability Company's principal executive office is:

4676 HIGHWAY 41 NORTH SPRINGFIELD TN 37172

(Street Address)

(City)

(State/County/Zip Code)

8. Period of Duration: PERPETUAL

9. Other Provisions:

10. THIS COMPANY IS A NON-PROFIT LIMITED LIABILITY COMPANY (Check if applicable)

10/13/05

Signature Date

OWNER

Signer's Capacity

Bart Posey

Signature (manager or member authorized to sign by the Limited Liability Company)

BART POSEY

Name (typed or printed)

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due: \$50 per member, with a minimum fee of \$300 and a maximum fee of \$3000. There is an additional fee of \$20 if any changes are made in block #8 to the registered agent/office.

Please return completed form to: TENNESSEE SECRETARY OF STATE Attn: Annual Report 312 Eighth Avenue N. 6th Floor William R. Snodgrass Tower Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 THIS REPORT IS DUE ON OR BEFORE: 04/01/06

1) SECRETARY OF STATE CONTROL Number: 0507138

2A.) NAME AND MAILING ADDRESS OF COMPANY SMART DATA SOLUTIONS LLC 4676 HWY 41 NORTH SPRINGFIELD, TN 37172

(2B.) STATE OR COUNTRY OF FORMATION TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS: RECEIVED STATE OF TENNESSEE 2007 APR 26 AM 11:41 RILEY DARRILL SECRETARY OF STATE

6044.1419

D 11/22/2005 FOR PROFIT (3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE: 4676 HWY 41 NORTH, SPRINGFIELD, TN 37172

B. CHANGE OF PRINCIPAL ADDRESS: STREET CITY STATE ZIP CODE + 4

(4) This LLC is: [] BOARD MANAGED [] DIRECTOR MANAGED [] MANAGER MANAGED [X] MEMBER MANAGED (check one box) If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

Table with 3 columns: NAME, BUSINESS ADDRESS, CITY, STATE, ZIP CODE + 4

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

Table with 3 columns: NAME, BUSINESS ADDRESS, CITY, STATE, ZIP CODE + 4. Entry: BART POSEY, 4676 Hwy 41 N, Springfield, TN 37172

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS: BART POSEY B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS: 4676 HWY 41 NORTH, SPRINGFIELD, TN 37172 C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE

(I.) CHANGE OF REGISTERED AGENT: (II.) CHANGE OF REGISTERED OFFICE (Street Address): (City) (State) TN (Zip Code + 4) (County)

(7) Number of members on the date the annual report is executed if there are more than six (6) members: [] This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE: [Signature] (9) DATE: 4-25-07 (10) TYPE/PRINT NAME OF SIGNER: BART POSEY (11) TITLE OF SIGNER: President/Manager

** THIS REPORT MUST BE DATED AND SIGNED **



SECRETARY OF STATE
CORPORATIONS SECTION
WILLIAM R. SNODGRASS TOWER
312 EIGHTH AVENUE NORTH - SIXTH FLOOR
NASHVILLE, TENNESSEE 37243-0306

ISSUANCE DATE: 06/14/06
CONTROL NUMBER: 0507138

5809.0935

BART POSEY
4676 HWY 41 NORTH
SPRINGFIELD, TN 37172

RE: SMART DATA SOLUTIONS LLC

NOTICE OF DETERMINATION

Pursuant to the provisions of Sections 48-245-301 or 48-246-501 of the Tennessee Limited Liability Company Act or Sections 48-249-604 or 48-249-908 of the Tennessee Revised Limited Liability Company Act, it has been determined that the following ground(s) exist(s) for the administrative dissolution of the above limited liability company, if a Tennessee limited liability company, or revocation of its certificate of authority, if a foreign limited liability company:

The Limited Liability Company Annual Report which was due on or before 04/01/06 has not been filed. To obtain an annual report form or for additional information, please call this office at (615) 741-2286.

If the limited liability company does not correct each ground for dissolution/revocation or provide evidence that each ground does not exist within two (2) months after issuance date of this notice, the limited liability company shall be administratively dissolved/revoked, as appropriate. For assistance in this regard, please contact this office at the appropriate telephone number listed above.

SECRETARY OF STATE
CORPORATIONS SECTION
WILLIAM R. SNODGRASS TOWER
312 EIGHTH AVENUE NORTH - SIXTH FLOOR
NASHVILLE, TENNESSEE 37243-0306

EFFECTIVE DATE: 08/21/06
TELEPHONE CONTACT: (615) 741-2286
CONTROL NUMBER: 0507138

BART POSEY
4676 HWY 41 NORTH
SPRINGFIELD, TN 37172

5835.1784

RE: SMART DATA SOLUTIONS LLC

CERTIFICATE OF ADMINISTRATIVE DISSOLUTION

Pursuant to the provisions of Sections 48-245-302 or 48-246-502 of the Tennessee Limited Liability Company Act or Sections 48-249-605 or 48-249-909 of the Tennessee Revised Limited Liability Company Act, this constitutes notice that the above limited liability company is hereby administratively dissolved, if a Tennessee limited liability company, or that its certificate of authority is revoked, if a foreign limited liability company, for the following reason(s):

For failure to file the Limited Liability Company Annual Report, as required by the Tennessee Limited Liability Act or the Tennessee Revised Limited Liability Company Act, as applicable.

The limited liability company or its certificate of authority may be reinstated upon the elimination of the above ground(s) and the filing of an application for reinstatement. The limited liability name must be available and otherwise satisfy the requirements of Section 48-207-101 of the Tennessee Limited Liability Act or Section 48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable. The reinstatement application fee is Seventy Dollars (\$70.00).

LIMITED LIABILITY COMPANY ANNUAL REPORT

Annual Report Filing Fee Due: \$50 per member, with a minimum fee of \$300 and a maximum fee of \$3000. There is an additional fee of \$20 if any changes are made in block #6 to the registered agent's office.

Please return completed form to: TENNESSEE SECRETARY OF STATE Attn: Annual Report 312 Eighth Avenue N. 5th Floor William R. Snodgrass Tower Nashville, TN 37243

CURRENT FISCAL YEAR CLOSING MONTH: 12 THIS REPORT IS DUE ON OR BEFORE: 04/01/07

(1) SECRETARY OF STATE CONTROL Number: 0507138

2A.) NAME AND MAILING ADDRESS OF COMPANY: SMART DATA SOLUTIONS LLC 4676 HWY 41 NORTH SPRINGFIELD, TN 37172 D 11/22/2005 FOR PROFIT

(2B.) STATE OR COUNTRY OF FORMATION: TENNESSEE (2C.) ADD OR CHANGE MAILING ADDRESS: [Blank] RECEIVED STATE OF TENNESSEE 2007 APR 26 AM 11:45 RILEY DARNELL SECRETARY OF STATE

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE: 4676 HWY 41 NORTH, SPRINGFIELD, TN 37172 B. CHANGE OF PRINCIPAL ADDRESS:

STREET CITY STATE ZIP CODE + 4

(4) This LLC is [] BOARD MANAGED [] DIRECTOR MANAGED [] MANAGER MANAGED [X] MEMBER MANAGED (check one box) If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

Table with 3 columns: NAME, BUSINESS ADDRESS, CITY, STATE, ZIP CODE + 4. Row 1: BART POSEY, 4676 Hwy 41 N, Springfield, TN 37172

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), (or their equivalent), respectively. Attach an additional sheet if necessary.

Table with 3 columns: NAME, BUSINESS ADDRESS, CITY, STATE, ZIP CODE + 4. Row 1: BART POSEY, 4676 Hwy 41 N, Springfield, TN 37172

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS: BART POSEY B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS: 4676 HWY 41 NORTH, SPRINGFIELD, TN 37172 C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: (ii.) CHANGE OF REGISTERED OFFICE (Street Address): (City) (State) TN (Zip Code +4) (County)

(7) Number of members on the date the annual report is executed if there are more than six (6) members: [] This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE: [Signature] (9) DATE: 4-25-07

(10) TYPE/PRINT NAME OF SIGNER: BART POSEY (11) TITLE OF SIGNER: Pres/Manager

** THIS REPORT MUST BE DATED AND SIGNED **



6044.1431

RECEIVED
STATE OF TENNESSEE

State of Tennessee



Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REINSTATEMENT
FOLLOWING ADMINISTRATIVE
DISSOLUTION/REVOCATION
(LLC)

2007 APR 26 AM 11:42

RILEY DARNELL
SECRETARY OF STATE

Pursuant to the provisions of 548-245-303 or 548-246-503 of the Tennessee Limited Liability Company Act or 548-259-606 or 548-249-910 of the Tennessee Revised Limited Liability Company Act, this application is submitted to the Tennessee Secretary of State for reinstatement.

1. The name of the Limited Liability Company is Smart Data Solutions, LLC
(Name change if applicable) _____

2. The effective date of its administrative dissolution/revocation is April 1/2006
(must be month, day and year)

3. The ground(s) for the administrative dissolution/revocation
 did not exist.
 has/have been eliminated.
[NOTE: Please mark the applicable box]

4. The Limited Liability Company name as listed in number one (1) satisfies the name requirements of Tennessee Limited Liability Company Act or Tennessee Revised Limited Liability Company Act, as applicable.

5. The Limited Liability Company control number assigned by the Secretary of State, if known is _____

4/26/07
Signature Date
OWNER/PRESIDENT
Signer's Capacity

Smart Data Solutions, LLC
Name of Limited Liability Company
Bart Posey
Signature
BART POSEY
Name (typed or printed)

6044.1423

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 04/26/07
REQUEST NUMBER: 6044-1423
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 04/26/07 1142
EFFECTIVE DATE/TIME: 04/26/07 1142
CONTROL NUMBER: 0507138

TO:
SMART DATA SOLUTIONS LLC
4676 HWY 41 N

SPRINGFIELD, TN 37172

RE:
SMART DATA SOLUTIONS LLC
APPLICATION FOR REINSTATEMENT - DOMESTIC
LIMITED LIABILITY COMPANY

6050.0385

IT HAS BEEN DETERMINED THAT THE ATTACHED APPLICATION FOR REINSTATEMENT CONTAINS THE INFORMATION REQUIRED BY STATUTE, THEREFORE THE ABOVE LIMITED LIABILITY COMPANY IS HEREBY REINSTATED, OR IF A FOREIGN LIMITED LIABILITY COMPANY, ITS CERTIFICATE OF AUTHORITY IS REINSTATED.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE LIMITED LIABILITY COMPANY CONTROL NUMBER GIVEN ABOVE.

FOR: APPLICATION FOR REINSTATEMENT - DOMESTIC
LIMITED LIABILITY COMPANY

ON DATE: 04/26/07

FROM:
SDS, LLC
4676 HWY 41 NORTH

SPRINGFIELD, TN 37172-0000

RECEIVED: FEES \$0.00
\$70.00
TOTAL PAYMENT RECEIVED: \$70.00

RECEIPT NUMBER: 00004166207
ACCOUNT NUMBER: 00508916



SS-4458

Riley C. Darnell

RILEY C. DARNELL
SECRETARY OF STATE

LIMITED LIABILITY COMPANY ANNUAL REPORT

Please return completed form to:
TENNESSEE SECRETARY OF STATE
 Attn: Annual Report
 312 Eighth Avenue N. 6th Floor
 William R. Snodgrass Tower
 Nashville, TN 37243

Annual Report Filing Fee Due:
 \$50 per member, with a minimum fee of \$300 and a maximum fee of \$3000.
 There is an additional fee of \$20 if any changes are made in block #6 to the
 registered agent/office.

CURRENT FISCAL YEAR CLOSING MONTH: 12 THIS REPORT IS DUE ON OR BEFORE: 4/1/08

(1) SECRETARY OF STATE CONTROL Number: 0507138

(2A.) NAME AND MAILING ADDRESS OF COMPANY
SMART DATA SOLUTIONS LLC
4676 HWY 41 NORTH
SPRINGFIELD, TN 37172

(2B.) STATE OR COUNTRY OF FORMATION
TENNESSEE

(2C.) ADD OR CHANGE MAILING ADDRESS:
Not Applicable

D 11/22/2005 FOR PROFIT

(3) A. PRINCIPAL ADDRESS INCLUDING CITY, STATE, ZIP CODE:
4676 HWY 41 NORTH, SPRINGFIELD, TN 37172

B. CHANGE OF PRINCIPAL ADDRESS:
Not Applicable

STREET CITY STATE ZIP CODE + 4

(4) This LLC is BOARD MANAGED DIRECTOR MANAGED MANAGER MANAGED MEMBER MANAGED (check one box)
 If board, director, or manager managed, provide the names and business addresses, including zip codes, of the governors, directors, or managers (or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
<u>Not Applicable</u>		

(5) Provide the names and business addresses, including zip codes, of the LLC managers (if governed by the LLC Act), or any officers (if governed by the Revised LLC Act), or their equivalent), respectively. Attach an additional sheet if necessary.

NAME	BUSINESS ADDRESS	CITY, STATE, ZIP CODE + 4
<u>Bart Posey</u>	<u>4676 Hwy 41 North</u>	<u>Springfield TN 37172</u>
<u>Angie Posey</u>	<u>4676 Hwy 41 North</u>	<u>Springfield TN 37172</u>

RECEIVED
 CLERK OF STATE
 TENNESSEE
 AUG 18 PM 1:40
 ALEX DARNELL
 SECRETARY OF STATE

(6) A. NAME OF REGISTERED AGENT AS APPEARS ON SECRETARY OF STATE RECORDS:
BART POSEY

B. REGISTERED ADDRESS AS APPEARS ON SECRETARY OF STATE RECORDS:
4676 HWY 41 NORTH, SPRINGFIELD, TN 37172

C. INDICATE BELOW ANY CHANGES TO THE REGISTERED AGENT NAME AND/OR REGISTERED OFFICE.

(i.) CHANGE OF REGISTERED AGENT: _____

(ii.) CHANGE OF REGISTERED OFFICE (Street Address): _____
 (City) _____ (State) TN (Zip Code +4) _____ (County) _____

(7) Number of members on the date the annual report is executed if there are more than six (6) members: _____
 This LLC is prohibited from engaging in business in Tennessee (check box if applicable).

(8) SIGNATURE Angie Posey (9) DATE August 14, 2008

(10) TYPE/PRINT NAME OF SIGNER Angie Posey (11) TITLE OF SIGNER Secretary

**** THIS REPORT MUST BE DATED AND SIGNED ****



6364.1120

SECRETARY OF STATE
CORPORATIONS SECTION
WILLIAM R. SNODGRASS TOWER
312 EIGHTH AVENUE NORTH - SIXTH FLOOR
NASHVILLE, TENNESSEE 37243-0306

ISSUANCE DATE: 06/17/08
CONTROL NUMBER: 0507138

6325.1376

BART POSEY
4676 HWY 41 NORTH
SPRINGFIELD, TN 37172

RE: SMART DATA SOLUTIONS LLC

NOTICE OF DETERMINATION

Pursuant to the provisions of Sections 48-245-301 or 48-246-501 of the Tennessee Limited Liability Company Act or Sections 48-249-604 or 48-249-908 of the Tennessee Revised Limited Liability Company Act, it has been determined that the following ground(s) exist(s) for the administrative dissolution of the above limited liability company, if a Tennessee limited liability company, or revocation of its certificate of authority, if a foreign limited liability company:

The Limited Liability Company Annual Report which was due on or before 04/01/08 has not been filed. To obtain an annual report form or for additional information, please call this office at (615) 741-2286.

If the limited liability company does not correct each ground for dissolution/revocation or provide evidence that each ground does not exist within two (2) months after issuance date of this notice, the limited liability company shall be administratively dissolved/revoked, as appropriate. For assistance in this regard, please contact this office at the appropriate telephone number listed above.

SERVE AMERICA ASSURANCE


Administrative Office
SDS, LLC
4676 Highway 41 North
Springfield, TN 37172

MASTER POLICY OF INSURANCE

This is your Master Policy of Insurance for your Association. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and US. The Policyholder is shown on the Schedule.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payments are determined by all the terms, conditions and limitations of the Policy. The Policy may be amended from time to time without your Consent or notice to you. Any such amendment will not affect a claim starting before the Amendment takes effect.

The Policy has been issued and delivered to the Policyholder. The Policy is held by the Policyholder. As a participant of the Policy, you may inspect it at any time during business hours at the office of the Policyholder.



President

HIGH DEDUCTIBLE MAJOR MEDICAL EXCESS COVERAGE

NON-PARTICIPATING

TABLE OF CONTENTS

GENERAL DEFINITIONS	3
ADDITIONAL DEFINITIONS	6
CONDITIONS OF INSURANCE	8
ELIGIBILITY	8
EFFECTIVE DATE	8
TERMINATION	9
Medical Expense Benefit	10
GENERAL EXCLUSIONS	10
PRE-EXISTING CONDITIONS LIMITATION	11
COORDINATION OF BENEFITS PROVISION	12
PREFERRED PROVIDER BENEFIT	15
CLAIM PROVISIONS	16
Notice of Claim	16
Claim Form	16
Proof of Loss	16
Time of Payment of Claims	16
Payment of Claims	16
Physical Examination	16
Legal Actions	16
Subrogation	16
PREMIUM	17
Payment of Premium/Due Date	17
Returned or Dishonored Payment	17
Change in Premium Rates	17
Grace Period	17
Reinstatement	17
GENERAL PROVISIONS	18
Entire Contract Changes	18
Time Limit on Certain Defenses	18
Misstatement of Age	18
Other Insurance with Us	18
Non-Participating	18
Conformity with State Statutes	18
Workers Compensation	18
Clerical Error	18
Information and Records	18

GENERAL DEFINITIONS

Accident: A sudden, unforeseen event which results in injury.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory authority to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the necessary care. Air ambulance charges are payable only for the transportation from the site of an emergency to the nearest available Hospital that is equipped to treat the condition instead of local ground Ambulance service.

Class: A category of persons based on student status, job, salary or some other condition of employment or membership. Eligible classes are shown on the Schedule.

Company: SERVE AMERICA ASSURANCE. Also hereinafter referred to as We, Us, and Our.

Complications of Pregnancy: A condition which 1) When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: a) acute nephritis; b) nephrosis; c) cardiac decomposition; d) missed abortion; e) eclampsia; f) puerperal infection; g) R.H. Factor problems; h) severe loss of blood requiring transfusion; i) and other similar medical and surgical conditions of comparable severity related to pregnancy; or when pregnancy is terminated: a) non-elective caesarean section; b) ectopic pregnancy that is terminated; and c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of pregnancy will not include: a) false labor; b) occasional spotting; c) Doctor prescribed rest during the period of pregnancy; d) morning sickness; e) preclampsia; and f) Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to the child or mother.

Covered Charge: The reasonable and customary charge incurred for a service or supply which is performed or given under the direction of a Doctor for Medically Necessary treatment of a sickness or injury which is covered by the Policy and incurred by a Covered Person. That portion of any charge which is in excess of the Reasonable and Customary charge for a particular service or supply in the area where it is incurred is not a covered charge. A covered charge is considered incurred on the date the treatment or service rendered or the supply is furnished.

Covered Person: A Person: a) who is eligible for coverage as the insured or as a Dependent; b) Who has been accepted for coverage or has been automatically added; c) who has paid the required premium; and d) whose coverage has become effective and is not terminated.

Dependent: A person who is the insured's: a) Legally married spouse residing with the insured; b) child who is dependent upon the insured for support and maintenance and is under the age of nineteen (19); c) Child who is dependent upon the insured for support and maintenance, is between 19 and 25 years of age and is attending school full-time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the insured's unmarried: a) natural child; b) stepchild; A stepchild is a dependent on the date the insured marries the child's parent; c) adopted child, including a child placed with the insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

In the event both parents of a dependent child are insured persons, such child is considered a dependent of either parent. The child may not be considered a dependent of both parents.

Doctor: A legally qualified person licensed in the healing arts and practicing within scope of his or her license and is not a direct Family Member.

Emergency: A sickness or injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following: a) the patient's life or health would be in serious jeopardy; b) bodily functions would be seriously impaired; or c) a body organ would be seriously damaged.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if reliable evidence shows that's the prevailing opinion among experts regarding the drug, device or medical care and treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Family member: A person who is related to the Covered Person, in any of the following ways; spouse, brother-in-law, sister-in-law, daughter-in-law, son-in-law, mother or father-in-law, parent (includes stepparent), brother, sister (includes stepsister or brother), or child (includes legally adopted or step-child). A Family Member includes an individual who normally lives in the Covered Person's household.

Hospital: An Institution licensed, accredited or certified by the State which: a) is accredited by the Joint Commission of Accreditation of Healthcare Organizations; b) Provides 24-hour nursing service by licensed registered nurses, (RN); c) mainly provides diagnostic and therapeutic care under the supervision of Doctors while hospital confined; and d) maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged, a nursing home, or an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse, except as specifically provided in the Policy
Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 24 consecutive hours for which a room and board charge is made by reason of sickness or injury for which benefits are payable.

Injury: Bodily injury due to an accident which: a) results solely, directly and independently of disease or bodily infirmity; b) Occurs after the Covered Person's effective date of coverage; and c) Occurs while coverage is in force.

All injuries sustained in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of a sickness or injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it;

- a) Is experiment/investigational or for research purposes;
- b) is provided solely for educational purposes or the convenience of the patient, the patients family, Doctor, Hospital or any other provider;
- c) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where on going treatment is merely for maintenance or preventative care;
- d) could have been omitted without adversely affecting the patient's condition or the quality of medical care;
- e) involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA);
- f) involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues manual; or
- g) can be safely provided to the patient in a more cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is medically necessary.

Mental or Nervous Disorder: Nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a covered person.

Policyholder: The entity shown as the Policyholder on the Schedule

Pre-Existing Condition: A Sickness or injury for which medical care, treatment, diagnosis or advice was received or recommended within the 12 month period immediately prior to the Covered Person's effective date of coverage under the Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months prior to the covered person's effective date of coverage under this Policy. Treatment includes taking of Prescriptions Medicines or drugs.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal Law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current AMA policies.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: a) the actual amount charged by the provider; b) the negotiated rate, if any; or c) the charge which would have been made by the provider of medical services for a comparable service or supply made by other providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary Charges, Fees or Expenses will be based on statistically valid data for the most current medical and surgical codes and nomenclature and will be updated at least every six months.

In determining whether a charge is reasonable, We may consider such factors as We, in the reasonable exercise of Our discretion, determine are appropriate, including but not limited to: a) the complexity of the service or supply involved; b) the degree of professional skill, experience and training required for a Doctor to be able to perform the procedure or service; c) the severity or nature of the Injury or Sickness being treated; d) the provider's adherence or failure to adhere to charging and billing practices generally accepted by the established United States medical society as determined by Us; or e) the cost to the provider of providing the service or supplies, or performing the procedure.

Sickness: Illness and disease which begin after the effective date of a Covered Person's coverage.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of filling and caps and is not carious, abscessed, or defective.

You, Your and Yours: The insured shown in the Schedule

We, Ours, and Us: The SERVE AMERICA ASSURANCE

ADDITIONAL DEFINITIONS

Calendar Year: The period of time beginning January 1 and ending on December 31 of the same year. The first Calendar year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31st after a Covered Person's effective date of coverage.

Durable Medical Equipment: A device which: a) is primarily and customarily used for medical purposes, is specifically equipped with features and functions that are generally not required in the absence of sickness or injury and is able to withstand repeated use; b) is used exclusively by the patient; c) is routinely used in a Hospital but can be used effectively in a non-medical facility; d) can be expected to make a meaningful contribution to the patient's sickness or injury; and e) is prescribed by a Doctor and the device is medically necessary for rehabilitation.

Durable medical equipment does not include: a) comfort and convenience items; b) equipment that can be used by Family members other than the covered person; c) health exercise equipment; and d) equipment that may increase the value of the insured's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to, modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Home Health Care: The provision of health service in the patient's residence under a plan of care established, approved in writing by the attending Doctor and certified by the attending Doctor as an alternative to Hospital Confinement or confinement in a skilled nursing facility. Each visit by a representative of a Home Health Agency is considered as one Home Health Care visit. Four hours of home health aide service is considered as one Home Health Care Visit. If service extends beyond four hours, each four hour or portion of that period is considered as one Home Health Care visit.

Home Health Care includes: part time nursing care by or supervised by a licensed registered nurse part-time home health care aid services which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; and medical supplies. Orthopedic appliances; durable medical equipment; prescription drugs and insulin, but only to the extent that such charges would have been considered covered expenses had the patient required Hospital Confinement or confinement in a skilled nursing facility.

Home Health Agency: An Agency or organizational that: a) Specializes in giving nursing care or therapeutic services in the home; b) is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVIII of the Social Security Act of 1965, as amended; c) is operating within the scope of its license or certification; and d) maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even if the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Agency.

Hospice: means an agency which provides a coordinated, interdisciplinary program for meeting the physical, psychological and social needs of a dying person and their families. A Hospice must: a) Be certified as a Hospice care program by Medicare; b) meet the standards of the National Hospice Organization, the Joint Commission of Accreditation of Hospitals, or similar standards; c) operate primary for Hospice Care; and d) provide full time supervision of at least one Doctor.

Hospice Care: Services provided by a Hospice providing care to an individual for whom a certified medical prognosis has been made indicating life expectancy of 6 months or less and who has elected to receive such care in lieu of other medical benefits provided herein.

Intensive Care: A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the surgical recovery room and from other rooms, beds and wards customarily used for patient care. Additionally they must be staffed and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusive to the intensive care unit.

Intensive Care Unit does not mean any of these step-down units: Progressive care intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for intensive care.

Medicaid: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Medicare: The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as the Constituted or Later Amended.

Nurse: A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who: a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and b) provides medical services which are within the scope of the nurse's license or certificate.

Physiotherapy: Any form of the following administered by a Doctor: a) physical or mechanical therapy; b) diathermy; c) ultra-sound therapy; d) heat treatment in any form; or e) manipulation or massage.

Skilled Nursing Care: A place that meets all of the following requirements: a) Is legally operated as a Skilled Nursing Facility; b) primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Doctor; c) provides continuous 24-hour a day nursing service by or under the supervision of a licensed nurse; and d) maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval upon request.

Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for rest, residential, retirement, or custodial care.

CONDITIONS OF INSURANCE

ELIGIBILITY

Insured: You are eligible for coverage when you complete a valid application, meeting Our underwriting standards for coverage and pay the initial premium.

Dependent Spouse: Your dependent lawful spouse is eligible for coverage the later of: a) the date You become eligible for insurance; or b) The date of the marriage to You.

Your dependent spouse must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

Dependent Child: A dependent child is eligible for coverage on the later of: a) the day You become eligible for insurance; or b) the date you acquire the dependent child.

A dependent child is deemed to be acquired as follows: a) Natural birth: On date of birth; b) Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement; or c) Stepchild: On the date of Your marriage to the child's parent.

Your dependent child (ren) must complete a valid application, meeting Our underwriting standards for coverage, and pay the initial premium.

EFFECTIVE DATE

Insured and Dependents, except Dependents Acquired After the Effective Date: Coverage is effective as stated on the schedule.

Dependents Acquired After Effective Date

Newborn Children: Your newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However you must notify Us in writing within 31 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child to continue beyond such 31 day period.

Adopted Child: Coverage for an adopted child is effective upon the date of placement for adoption. Coverage for such child will be for sickness and injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, You must notify Us in writing within the 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child to continue beyond such 31 day period.

"Placement for Adoption" means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with You terminates upon the termination of the legal obligations.

Dependent Spouse: A dependent spouse is eligible for coverage on the date of lawful marriage to You. Application and premium must be received within 31 days of the marriage. Coverage will become effective following Our acceptance of the spouse's application and payment of the required premium.

Enrollment under Court Orders: If pursuant to a court order which meets the specifications of 20-7-1200 of the statutes, You are required to provide health coverage for a child and You are eligible for dependent coverage, we shall: a) permit you to enroll a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions; b) if you are enrolled but fail to make application to

obtain coverage for the child, enroll the child under the Policy upon applications of: 1) the child's other parent; 2) the state agency administering the Medicaid program; or 3) the state agency administering 42 U.S.C. 651 to 699, the child support enforcement program; and c) continue coverage of the child unless We are provided satisfactory written evidence that: 1) Court order is no longer in effect; 2) Child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or 3) the Policyholder has eliminated family health coverage for all its members.

TERMINATION

Covered Person: Coverage with respect to a covered person will terminate at 12:01 A.M. standard time at your residence on the earliest of: a) the date the Policy terminates; b) the date coverage is terminated by Us for all certificate holders in your state; c) the date we receive your written request to terminate coverage; d) the last day of the period for which the premium is paid; e) the last day of the period for which premium has been paid following the date a dependent ceases to be a dependent as defined; or f) the date a covered person enter full time military service. Upon written request within 30 days of entering the military, We will refund any unearned premium pro-rata with respect to such person.

At least 45 days prior to written notice will be given to you if We terminate your coverage for any reason, except nonpayment of premium.

If We discontinue the Policy form or plan of Insurance, We will provide you 90 days written notice and the opportunity to purchase without submitting proof of good health, any similar insurance coverage which we offer in that state. If we uniformly discontinue all coverage in a market in your state of residence, We will provide you at least 90 days written notice before the coverage terminates.

The continued coverage will cover the covered person and his insured dependents.

Continued coverage will terminate on the earlier of: a) the date 18 months after the date on which the group coverage would otherwise have terminated because of termination of the group membership. B) if the covered person fails to make timely payment of premium, the end of the period for which premium payment was made; or c) the date the Policy is terminated and is not replaced by another group policy within 31 days.

If a group policy is replaced, covered persons covered under continued coverage shall remain under such coverage under the replaced policy until as provided in the termination of Continued Coverage provision.

In the Event of Dissolution of Marriage

If your marriage is dissolved by a valid decree of dissolution and if your spouse is a covered person on the date of the decree of dissolution then the dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the dependent spouse continues coverage pursuant to this provision, we will issue him or her a new Certificate as evidence of coverage under the Policy.

For a Dependent child reaching the limiting age

If a dependent child no longer qualifies as a dependent, then the dependent child's coverage will continue in force under the policy, subject to its provisions, if the dependent child pays the first premium required for continued coverage within 31 days after the date her or she no longer qualifies as a dependent child.

If the dependent child continues coverage pursuant to this provision, we will issue him or her a new certificate as evidence of coverage under the Policy.

MEDICAL EXPENSE BENEFITS

We will pay for Covered Charges incurred by the covered person due to Sickness or Injury while covered under the Policy. Covered charges as defined and limited are shown on the Schedule and are, during a Calendar Year, subject to: a) deductible; b) insured percent; c) out-of-pocket maximums; d) coordination of benefits; e) the lifetime aggregate maximum amount; and f) definitions, limitations, exclusions and other provisions of the Policy.

Deductible: A dollar amount of covered charges a covered person must pay each calendar year before benefits are paid. The deductible is shown in the Schedule. A new deductible will apply each calendar year.

Insured Percent: The percentage of covered charges we pay for covered charges during each calendar year after the deductible is satisfied. The insured percent is shown in the Schedule.

Calendar Year Maximum: The maximum amount that will be paid in benefits within a calendar year.

Lifetime Aggregate Maximum Amount: The maximum amount of benefits We will pay while a covered person is covered under this Certificate. The Lifetime Aggregate Maximum Amount is inclusive of all benefit amounts received under this Certificate. The Lifetime Aggregate Maximum Amount is shown on the Schedule.

Out of Pocket Maximum: The amount of covered charges a covered person must pay during a Calendar Year before his or her benefits are paid at 100%. The Out-Of-Pocket Maximum is in addition to the Deductible and applies only to out-of-network expenses. The Out-of-Pocket Maximum is stated in the Schedule.

GENERAL EXCLUSIONS

We won't pay benefits for:

Treatment, services or supplies which:

- Are not Medically Necessary
- Are not prescribed by a Doctor as necessary treatment to treat a Sickness or Injury
- Are determined to be Experimental/Investigational in nature by Us
- Are received without charge or legal obligation to pay
- Would not routinely be paid in the absence of insurance
- Are received from family members
- Are received outside the United States

Expenses incurred as a result of loss due to war, declared or undeclared; service in the armed forces of any country.

Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.

Expenses incurred as a result of suicide or attempted suicide or intentionally self-inflicted injury whether sane or insane.

Injury or sickness arising out of or in the course of employment which is compensable under any Worker's Compensation or Occupational Disease Act or Law.

Cosmetic Surgery other than:

- a) reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
- b) reconstructive surgery because of a congenital disease or anomaly, except as provided for Dependent newborns.

Injury due to being legally intoxicated, as defined by the jurisdiction in which an accident occurs.

Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.

Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial scheduled airline.
Any service or supply not specifically listed as a covered charge.
Sexual reassignment surgery and related expenses.
Routine physical examinations, health examinations or preschool physical examinations including routine care of a newborn infant, other than Hospital nursery expense of a dependent newborn baby.
Temporomandibular Joint Dysfunction (TMJ)
Expenses incurred as a result of dental treatment or dental x-rays, except as specifically provided and then only when injury occurs to sound natural teeth.
Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription, therefore, or radial keratotomy or laser surgery; hearing aids or prescriptions or examinations, except as required for repair caused by injury.
Treatment of infertility, including diagnosis, diagnostic tests, medication, surgery, intrafallopian transfer and in vitro fertilization, or any other form of assisted contraception.
Manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, application of heat or cold.
Expenses to the extent they are paid under Medicare or any other government insurance plan (except Medicaid).
Expenses covered by automobile "no fault" contracts (group, group-type or individual).
Chelation treatments.
Artificial limbs or prosthetics, except as specifically provided.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing Conditions are not covered for the first twelve (12) months following a Covered Person's effective date of coverage under this Policy.

The Pre-existing Condition Limitation does not apply to: a) a newborn Dependent Child; or b) a child adopted by you or placed with you for adoption, if the adoption or placement for adoption occurs while you are covered under this Policy.

COORDINATION OF BENEFITS PROVISION

The following provisions are applied to determine which Insurance Plan pays benefits first when a Covered Person is covered by two or more plans. A Plan that pays first is called "Primary". All other plans called "Secondary".

If these provisions apply, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The Benefits of the Plan:

- (1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits first before another plan; but
- (2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of the Plan".

Definitions:

"Plan" is any of these which provide benefits or services for, or because of, medical or dental or treatment.

- (1) Group Insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- (2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.) as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"This Plan" is not part of the group contract that provides benefits for health care expenses.

"Primary Plan/Secondary Plan": The order of benefit determination rules state where this plan is a primary plan or secondary plan as to another plan covering the person.

- (1) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- (2) When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

- (3) When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary plan as to a different plan or plans.

“Allowable Expense” means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

- (1) The difference between the cost of a private room and a semi-private hospital room is not considered an allowable expense under the above definition unless the patient’s stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
- (2) When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a calendar year. However it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules:

General: When there is a basis for a claim under this Plan and another plan, this plan is a Secondary plan which has its benefits determined after those of the other plan, unless:

- (1) The other plan has rules coordinating its benefits with those of this Plan; and
- (2) Both those rules and this Plan’s rules, in subsection B below, require that this Plan’s benefits be determined before those of the other plan.

Rules: This Plan determines its order of benefits using the first of the following rules which apply:

- (1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that : if the person is also a Medicare beneficiary, Medicare is:
 - a. Secondary to the plan covering the person as a dependent; and
 - b. Primary to the plan covering the person as other than a dependent, for example a retired employee.
- (2) Dependent Child/Parents not separated or divorced. Except as state in subsection (b) (3) below, when this plan and another plan cover the same child as a dependent of a different person, called “parents”.
 - a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - c. However, if the other plan does not have the rule described in subsection (2) (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits the rule in the other plan will determine the order of benefits.
- (3) Dependent Child/ Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with the custody of the child; and
 - c. Finally, the plan of the parent not having custody of the child

- d. However, if the specific terms of a court decree state that one of the parents is responsible for health insurance expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.
- (4) **Dependent/ Child/Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III subsection (2) (b) above.
 - (5) **Active/Inactive Employee.** The benefit of a plan which covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.
 - (6) **Continuation coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination.
 - a. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);
 - b. Second, the benefits under the continuation coverage.
 - (7) **Longer/Shorter length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plans which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

Effects on the Benefits of the Plan

- (1) When this Section applies. This section applies when, in accordance with the above Section, "Order of Benefit Determination Rules." This Plan is Secondary plan as to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (2) immediately below.
- (2) **Reduction in this Plans Benefits.** The benefits of this Plan will be reduced when the sum of:
 - (a) The benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
 - (b) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable expenses.
 - (c) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply this COB rules. Insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Insurer needs not tell, or get

the consent of, any person to do this. Each person claiming benefits under this Plan must give insurer any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable case value of the benefits.

Right of Recovery

If the amount of the payment made by insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of: a) The persons it has paid or for whom it has paid; b) Insurance companies; or c) other organizations.

PREFEPPED PROVIDER BENEFIT

We encourage Covered Providers by providing benefit incentives when Preferred Providers are used.

In the event of an emergency, services rendered by any Hospital due to and within the first 24 hours after the onset of the emergency are covered as if the service had been provided by Preferred Hospital. After the first 24 hours, service rendered by a non-preferred Hospital to treat the emergency will continue to be covered as if rendered by a preferred provider only until the covered person can reasonably and safely be transferred to a preferred Hospital.

In the event a covered person is traveling or away from home, needs medical attention, and cannot use a Participating Provider for the area, contact our Customer Service department. We will refer the covered person to a participating provider that may be available in the area nearest to such person at the time. If there is no participating provider available benefits for covered charges will be subject to the reduced insured percentage and out-of-pocket maximum.

A covered person is not required to seek treatment from a preferred provider. Each covered person is free to elect the services of a provider and benefits payable will be made in accordance with the terms and conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a preferred provider or to their respective staff or Doctors. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the preferred provider, their staff or Doctors.

Out-of-Network: Any Hospital or Doctor that is not a member of the preferred provider network arrangement that has contracted with Us.

Preferred Provider: Any Hospital or Doctor that has contracted with Us to provide services, as described in this Certificate, through a preferred provider network arrangement, to be reimbursed at discounted rates.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim for loss must be given to Us or Our authorized representatives within 30 days after a covered loss starts, or, because of incapacity or some similar reason, as soon as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Form: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished by Us within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss submitting, within the time fixed in the Policy for filing the Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

Proof of Loss: Written Proof of Loss must be given to Us or Our authorized representative within 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as was reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper Proof of Loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

Payment of Claims: Benefits will be payable to You or the medical services provider if We have received a valid assignment by the covered person.

If any benefit is payable to the estate of a covered person or to a covered person who is a minor or otherwise not competent to give a valid release, we may pay the benefit, up to an amount not to exceed \$5,000, to any relative by blood or connection by marriage of the covered person who is considered by Us to be equitably entitled to the benefit.

Subject to any written direction of the covered person or of the legal or natural guardian of the covered person, if the covered person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular hospital or person.

Physical Examination: We, at Our expense, shall have the right and opportunity to examine the covered person as it may reasonably be required while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Policy within 60 days after written proof of loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a covered person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such covered person against any person who might be acknowledgedly liable or found legally liable by Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefit was paid. Such subrogation rights shall extend only to Our recovery of the benefits we have paid for such hospitalization and treatment and We shall pay fees and costs associated with such recovery.

If the Director of Serve America Assurance or his or her designee, upon being petitioned by a covered person, determines that the exercise of subrogation by Us is inequitable and commits an injustice to the covered person, subrogation under this provision is not allowed. This determination by the Director or his or her designee may be appealed by Us.

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at Our home office of by Our authorized representative.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under State law. A dishonored check shall be considered a failure to pay Premium and coverage will lapse.

Change in Premium Rates: We have the right to change the table of premium rates from time to time. Premiums will change if dependents are added or removed. If benefits are changed, or if a new table of premium rates applies. Premiums will also increase as your age and the age of other covered persons increase. A change in the table of premium rates or a premium increase due to age will be effective on the first premium due date following such written notice. We can only change the table of premium rates if We change it for all the policies with this form in your state.

Grace Period: We allow a grace period of 31 days for the payment of premium after the first premium is paid. Coverage is in force during the grace period. If at least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date of the non-renewal is to be effective. If you send written notice to Us that you are not renewing your coverage, then the grace period will not apply after the date the non-renewal is effective.

Coverage terminates on the last day for which premium has been paid.

Reinstatement: If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the business.

If We do not require an application for reinstatement and accept premium, then We may issue a conditional premium receipt. If we approve the application, then insurance will be reinstated as of the date of Our approval. If we do not approve the application, then We will notify you in writing within 45 days after the date of the application.

If we do not notify you within 45 days, then coverage will be reinstated on the 45th day after the date of the conditional premium receipt.

The reinstated Certificate will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, Your rights and Ours will be same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

GENERAL PROVISIONS

Entire Contract Changes: The policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

Failure by Us to enforce any Policy provision, shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Time Limit on Certain Defenses: After 2 years from the covered person's effective date, no misstatements, except fraudulent misstatements, made by the covered person in the application for such coverage shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the 2 year period.

No claim for loss incurred commencing after 2 years from the covered person's effective date shall be reduced or denied on the ground 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.

Misstatement of Age: If the age of the covered person has been misstated, all amounts payable under the Policy will be such as the premium paid would have been if purchased at the correct age.

Other Insurance with Us: Insurance effective at any one time on the insured under a like policy or policies with Us is limited to one such Policy elected by the Insured, his beneficiary or his estate, as the case may be and We will return all premiums paid for all other such policies.

Non-Participating: This Certificate is non-participating. It does not share in Our profits or surplus earnings.

Conformity with State Statutes: If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Workers Compensation: This certificate is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Clerical Error: If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: a) the Policyholder makes a written request for coverage on a form approved by Us; and b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the covered is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a covered person's coverage terminates.

SERVE AMERICA ASSURANCE

SCHEDULE

POLICYHOLDER

Realty Benefits Associates
1351 Forest Ave
PMB 124
Staten Island, New York 10302

MEDICAL EXPENSE BENEFITS

LIFETIME AGGREGATE MAXIMUM AMOUNT PER COVERED PERSON: \$1,000,000

ANNUAL CALENDAR YEAR MAXIMUM AMOUNT PER COVERED PERSON: \$250,000

DEDUCTIBLE, PER CALENDAR YEAR, PER COVERED PERSON: \$10,000

INSURED PERCENT (EXCEPT AS SPECIFICALLY STATED IN CHARGES)

IN-NETWORK: 100%

OUT-OF-NETWORK: An Additional Deductible of \$10,000 at 80%/20% then 100%

OUT-OF-POCKET MAXIMUM APPLIES ONLY TO OUT-OF-NETWORK SERVICES AND IS IN ADDITION TO THE DEDUCTIBLE.

COVERED CHARGES

Covered Charges are treatment, services or supplies incurred for:

INPATIENT

- Hospital room and board and general nursing care while Hospital Confined, up to the daily semi-private room rate
- Hospital miscellaneous charges, such as the cost of the operating room, laboratory tests, x-ray examinations.
- Speech and occupational therapy
- Intensive Care Unit/Hospital expenses, not to exceed 2 times the Hospital rate for semi-private room
- Doctor's fee for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession
- Anesthetist expenses
- Assistant surgeon's expense
- Pathologist expense
- Radiologist's expense
- Nurse expense for private duty nursing, when prescribed by the attending Doctor, up to \$250 a day, not to exceed \$10,000 per Calendar year
- Doctors visits
- Physiotherapy
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivative not replaced; charges for processing and administration of blood or blood derivatives
- Treatment of Mental or Nervous Disorders limited to a maximum benefit of \$10,000 per lifetime
- Treatment of alcoholism

OUTPATIENT

- Doctor's fees for surgery. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.
- Anesthetist expense
- Assistant surgeon's expense
- Doctor's visits
- Physiotherapy
- Emergency room expenses and supplies
- Diagnostic x-ray expense
- Laboratory services expense
- CAT Scan/MRI expense
- Radiation therapy and chemotherapy
- Dialysis treatment
- Blood and blood derivatives not replaced; charges for processing and administration of blood or blood derivatives

OTHER

- Rental and expense of wheelchairs, hospital beds and other Durable Medical Equipment of this type, not to exceed the purchase price
- Casts, splints, braces, trusses, crutches and other devices of this type

- Dental treatment for injury to sound natural teeth
- Rental of mechanical equipment for medical or surgical treatment, not to exceed the purchase price
- Home health care expense up to \$250 per week not to exceed \$10,000 lifetime
- Hospice care expense for up to six months per lifetime
- Bereavement counseling received from a hospice for the immediate family of the deceased covered person, up to \$500 lifetime
- Skilled nursing care up to \$250 per week not to exceed \$10,000 lifetime. Confinement must be prescribed by the attending Doctor. Skilled Nursing Care benefits will be paid only after the covered person was Hospital Confined for at least 3 consecutive days and Skilled Nursing Care begins within 14 days of such Hospital Confinement
- Ambulance expense, up to a maximum benefit of \$250 per trip, not to exceed \$1,000 per calendar year
- Prescription expense, up to a maximum benefit of \$10,000 lifetime

Applies Only to Dependent Children: Care and treatment of congenital cleft in the lip or palate or both, including but not limited to:

- Oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances
- Prosthodontic treatment and management
- Otolaryngology treatment and management
- Audio logical assessment, treatment, and management performed by or under the supervision of a Doctor of medicine, including surgically implanting amplification device; and
- Physical therapy assessment and treatment

Hospital Confinement for at least 48 hours following a mastectomy. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending Doctor. Prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the patient's attending Doctor.

SERVE AMERICA ASSURANCE PRIVACY NOTICE

At SERVE AMERICA ASSURANCE INSURANCE COMPANY, we know the importance of an individual's right to privacy. That's why protecting information that personally identifies you is high priority and a matter we take very seriously.

Our primary goal is, and will continue to be, provide you with competitive, exceptional quality insurance products to meet the long term financial needs of you and your family.

We want to assure you that the personal, financial and medical information you share with us for applying coverage to claims is the cornerstone in providing you the highest quality coverage we can for the most affordable price. That information, unique to you, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with you.

The following is a summary of our privacy policy and practices.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION

In order for SERVE AMERICA ASSURANCE to provide and administer the products we offer, we collect personal information about you. Some of the information we collect about you is non-public. The non-public information we collect is obtained from the following sources:

Information we receive from you on your application for insurance or other forms, such as your name, address, telephone number, age, social security number, and beneficiary designation.

Information about your transactions with us and our affiliates, such as the type of insurance products you buy, the premium you pay, the method of purchase and your payment history.

Information we receive from third party reports such as consumer reporting agencies, credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.

INFORMATION WE DISCLOSE

SERVE AMERICA ASSURANCE does not disclose any non-public information about our policyholders or former policyholders to anyone, except as permitted or required by law.

We may also disclose all of the information we collect as described above, with the following:

Affiliates – We may share information with our affiliates.

Service Providers – We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction that you request or authorize; to develop or maintain computer software; or to perform market research.

Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY

Your medical information is kept confidential. We will not use or share, internally or with third parties, your medical information except for the purpose of:

- Underwriting;
- Administering your policy or claim
- As permitted or required by law; or
- As authorized by you.

SECURITY AND CONFIDENTIALITY OF YOUR INFORMATION

We restrict access to nonpublic information about you to those employees (or people working on your behalf under confidentiality agreements) who need to know the information in order to provide products and services to you. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your non-public personal information.

Serve America, LTD

Administrative Office
SDS
4676 Highway 41 North
Springfield, TN. 37172

This Certificate explains the Limited Group Hospital Indemnity Insurance that is underwritten by Serve America, LTD. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice – Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is insured under the Group Master Policy ("Policy")

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to periodic changes.

The insurance made under this Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are insured and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required premium paid for each dependent.

Policyholder: American Trade Association

Governing Jurisdiction: Arkansas

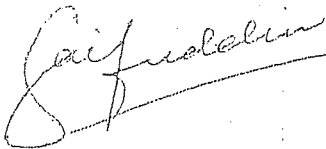
Policy Number: ATAI111

Insured:

Certificate Number:

Effective Date:

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.



President

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY INSURANCE

LIMITED BENEFIT - READ YOUR CERTIFICATE CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS

TABLE OF CONTENTS

<u>CERTIFICATE SECTIONS</u>	<u>PAGES</u>
SCHEDULE OF BENEFITS	3
DEFINITIONS	4
ELIGIBILITY AND EFFECTIVE DATE	5
BENEFIT PROVISIONS	6
EXCLUSIONS AND LIMITATIONS	7
PREMIUMS	8
TERMINATION OF INSURANCE	8
CLAIMS PROVISION	9
GENERAL PROVISIONS	10

SCHEDULE OF BENEFITS

INSURED:	CERTIFICATE NUMBER:
AGE AT ISSUE:	DEPENDENT COVERAGE:
INSURED EFFECTIVE DATE:	DEPENDENT EFFECTIVE DATE:
ANNUAL MAXIMUM BENEFIT LIMIT:	NONE

BENEFIT COVERAGE

EFFECTIVE DATE:	TYPE OF COVERAGE PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY AMOUNT BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER CONFINEMENT	\$500
DAILY INDEMNITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER YEAR PER MEMBER	\$500
IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT PER ADMISSION PER MEMBER: MAXIMUM VISITS PER YEAR PER MEMBER:	\$500 2
SURGICAL AND ANESTHESIA INDEMNITY BENEFIT BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE: BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	\$1,000 SCHEDULE EQUAL TO 20% OF SURGICAL BENEFIT AMOUNT
OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT BENEFIT AMOUNT PER OFFICE VISIT: MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	\$50 6
OFF-THE-JOB ACCIDENT INJURY BENEFIT MAXIMUM BENEFIT: MAXIMUM NUMBER PER YEAR PER MEMBER:	\$500 5
OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT BENEFIT AMOUNT PER VISIT PER MEMBER: CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	\$50 4

EFFECTIVE
DATE:

TYPE OF COVERAGE
PER COVERED PERSON

EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY
BENEFIT

BENEFIT AMOUNT PAID PER ER VISIT FOR SICKNESS
OR ILLNESS: \$50
MAXIMUM NUMBER OF VISITS PER YEAR: 2

WELLNESS INDEMNITY BENEFIT

BENEFIT AMOUNT PER VISIT PER MEMBER: \$50
MAXIMUM CALENDAR YEAR VISITS PER MEMBER: 1
WELL CHILD VISITS - 4 VISITS PER YEAR PER CHILD
FROM 0 MONTHS TO 12 MONTHS
WELL CHILD VISITS - 2 VISITS PER YEAR PER CHILD
FROM 12 MONTHS TO 24 MONTHS

DAILY IN-PATIENT DRUG & ALCOHOL INDEMNITY
BENEFIT

BENEFIT PER DAY OF CONFINEMENT IF INSURED: \$300
IS CONFINED IN A REHABILITATION FACILITY
FOR SUBSTANCE ABUSE
ANNUAL MAXIMUM BENEFIT: \$10,000
LIFETIME MAXIMUM OF \$30,000

DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY
BENEFIT

BENEFIT PER DAY OF CONFINEMENT IF INSURED: \$300
IS CONFINED IN A REHABILITATION FACILITY
FOR MENTAL OR NERVOUS DISORDERS
ANNUAL MAXIMUM BENEFIT: \$10,000
LIFETIME MAXIMUM OF \$30,000

EXPRESS SCRIPTS RX CARD BENEFIT

Insured prescription card - AWP less 16% discount
Then an 50% copay per prescription up to an annual
Benefit per member of \$500 then an Express Scripts
Discount plan beyond there - no pre-existing exclusions \$500

GROUP TERM LIFE INSURANCE POLICY WITH ACCIDENTAL
DEATH AND DISMEMBERMENT RIDER ATTACHED

PRIMARY MEMBER BENEFIT: \$5,000
SPOUSE: \$2,500
CHILD(REN) - NOT COVERED FOR AD&D BENEFIT \$2,500

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; and
- Those duties are performed at your place of business where You normally do such duties or at some location to which your employer sends you.

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day, and You were in Active Service on the last preceding regular work day.

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for this insurance coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity insurance coverage.

Child: A child of Yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with You; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with You, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while insured, and prior to reaching the limiting age of a Child. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, Your Spouse or Your Children, who has been accepted by Us for coverage.

Critical Illness: Any of the following conditions:

1. Cancer – A disease which is identified by the presence of a malignant tumor characterized by uncontrolled growth and spread of malignant cells, and the invasion of normal tissue. Cancer must be positively identified and diagnosed with histopathological conformation. Leukemia and Hodgkin's disease (except stage 1 Hodgkin's disease) will be considered Cancer.
 - Cancer does not include
 - o Pre-Malignant conditions or conditions with malignant potential;
 - o Prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1 (b), or of other equivalent or lesser classifications).
2. Skin Cancer – Basal cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides.
3. Carcinoma in situ – Cancer that is diagnosed with histopathological confirmation and confined to the site of the origin without having invaded neighboring tissue.
4. Heart Attack [the death (infarction) of a portion of heart muscle as a result of inadequate blood supply. The diagnosis must be based on all of the following criteria:
 - o a) Associated new electrocardiographic (EKG) changes consistent with Injury;
 - o b) Elevation of Cardiac enzymes; and
 - o c) Confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
5. Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolizations of brain tissue from an extracranial source. The diagnosis must be based on:
 - Documented neurological deficits; and
 - Confirmatory neuron-imaging studies

Stroke does not include cerebral symptoms due to:

- Transient ischemic attack (TIA);
 - Reversible neurological deficit;
 - Migraine;
 - Cerebral injury resulting from trauma or hypoxia; or
 - Vascular disease affecting the eye, optic nerve or vestibular functions.
6. End Stage Renal Failure – Chronic, irreversible failure of the function of both kidneys, such that a Covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly.
 7. Major Organ Transplant Surgery – A Covered person undergoing surgery as a recipient of a human to human transplant of a heart, lung, kidney or pancreas.

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability – The correct and complete answers to the questions in the Application of Enrollment Form and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered person.

Grace Period – The period of 31 days allowed for each premium payment after the first premium.

Group Master Policy or Policy: The complete contract of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to insureds, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each insured.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Insured – The employee or member covered for this insurance and named on the Cover page of this Certificate,

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Waiting Period – The period of time from your date of employment or membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The Insurer that underwrites this coverage: Serve America, LTD

You, Your, or Yours – The Insured.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for insurance You must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form and must provide evidence of Insurability satisfactory to us, if we ask for it; and
3. Be Actively at work. Either as a business owner, independent contractor, work for a small business or a member of a workers union.

Employee or Member Effective Date – Your insurance will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service; and
3. Your first premium is paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first premium must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required premium within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If you and your spouse are both eligible as an employee or member, the Children may be insured as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional premium.

BENEFIT PROVISIONS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is insured under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Daily In-Hospital Indemnity Benefit – If a Covered Person is confined in a hospital as a result of Accident or Sickness, We will pay the benefit amount per day shown on the schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Surgical and Anesthesia Indemnity Benefit – If a Covered Person undergoes a surgical procedure listed on the Table of Surgical Indemnity Benefits Schedule ("Surgical Table"), which is attached to this Certificate, as a result of a covered Accident or Sickness, We will pay the benefit shown on that Surgical table. We will also pay the benefit amount, if shown on the Schedule of Benefits, for the administration of anesthesia per surgical visit by a Physician in connection with the surgery.

If two or more procedures are performed through the same incision or operative field, the benefit paid will be for only the procedure that has the larger benefit. If more than one procedure is performed, but each through a separate incision or in the separate operative field, the amount payable will be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Representative surgeries have been listed in the Surgical Table. A complete Surgical Schedule has been filed with the State. We will pay all surgeries in accordance with that Surgical Schedule. With respect to surgical procedures that are not listed in the Surgical Schedule, We will pay an indemnity benefit that is consistent with similar procedures within the Surgical Schedule.

Outpatient Physician Office Visit Indemnity Benefit – We will pay this benefit as shown on the Schedule for a physician office visit as a result of an Accident or Sickness.

Off-the-Job Accidental Injury Benefit - We will pay benefits for the actual charges incurred for a covered Accident up to the amount shown on the Schedule for each Covered Person, for x-rays used to diagnose an Accidental Injury and treatment of a covered accident by a Physician in the Physician's office, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. For purpose of this benefit only, "actual charges" will mean the amount actually paid by or on behalf of the Covered Person and accepted by a Hospital or Physician for services provided.

Critical Illness Indemnity Benefit – The Critical Illness Indemnity Benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this certificate. A Benefit is payable for any one of the following:

Critical Illness – We will pay the amount shown on the Schedule for each Covered Person when he/she is first diagnosed as having a covered Critical Illness.

Skin Cancer – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed with Skin cancer.

Carcinoma In Situ – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed as having Carcinoma In Situ.

BENEFIT PROVISIONS (Continued)

Subsequent Critical Illness Indemnity Benefit – We will pay this benefit, in the amount specified on the Schedule of Benefits, when a Covered Person is first diagnosed as having a subsequent and separate covered Critical Illness. The subsequent Critical Illness must be a Critical Illness that is defined in a separate category of conditions than the first covered Critical Illness; the subsequent and separate covered Critical Illness must first manifest itself, and be diagnosed more than 60 days after the first covered Critical Illness is initially diagnosed. This subsequent Critical Illness benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this Certificate. This subsequent Critical Illness Benefit is not payable for Carcinoma In Situ or Skin Cancer.

Wellness Indemnity Benefit – We will pay this benefit as shown on the Schedule for each Covered Person who has undergone the following: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Intensive Care Indemnity Benefit – If a Covered Person is confined in an Intensive Care Unit as a result of Accident or Sickness, We will pay the benefit amount per day shown on the Schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Benefits When There is a Break in Service – If a covered Person's coverage terminates for any reason, and such person is re-enrolled for coverage as either an employee/member or Dependent under this Policy or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy, all benefits paid during the Calendar Year will be accumulated and applied towards the maximum benefit for the Calendar Year as described on the Schedule of Benefits, no matter how many times a Covered Person becomes insured under this or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy.

Physical Examinations and Autopsy – We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

Proof of Loss – Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a period payment is provided contingent upon continuing loss, each satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of said loss. Satisfactory written proof of loss includes but is not limited to: itemized Physician or Hospital bills, and, with regard to Critical Illness benefits, the initial pathology report diagnosing a Critical Illness.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the date of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims – benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. Suicide or any attempt thereof, while sane or insane;
2. Any intentional self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless the Wellness Indemnity Benefit is shown the Schedule of Benefits);
5. Routine newborn care (unless covered under the Wellness Indemnity Benefit on the Schedule of Benefits);
6. The treatment of:
 - a. Mental illness, functional or organic nervous disorder, regardless of cause (unless the Daily In-Patient Mental and Nervous Benefit is shown the Schedule of Benefits);
 - b. Alcohol abuse or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed (unless the Daily In-Patient Drug and Alcohol Benefit is shown the Schedule of Benefits);
7. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
8. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
9. Participation in:
 - a. An organized contest of speed;
 - b. Parachuting;
 - c. Parasailing;
 - d. Bungee jumping; or
 - e. Hang Gliding;
10. Air travel, except:
 - a. As a fare-paying passenger on a commercial airline on a regularly scheduled route; or,
 - b. As a passenger for transportation only and not as a pilot or crew member;
11. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
12. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
13. The reversal of a tubal ligation or vasectomy;
14. Artificial insemination, in vitro fertilization, and test tube fertilization, including an relate testing, medications or Physician's services, unless required by law;
15. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as result of this exception.);
16. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
17. Air or ground ambulance transportation (unless the Ambulance Benefit is shown on the Schedule);
18. Routine eye examinations or fitting of eye glasses;
19. Hearing aids or fitting of hearing aids;
20. Dental examinations or dental care other than expenses resulting from an Accident;
21. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
22. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
23. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war.

PREMIUMS

All premiums are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the premium rates on any premium due in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder. If an increase takes place on other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due the coverage will automatically be terminated as of the date the pro rate premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increase Our liability, premium rates may be changed on the date that Our liability is increased, without regard to any premium rate guarantee.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.
- 5.

The Insurance on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which premium payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.
- 5.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits – Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms – Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure – Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim – Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Payment of Benefits – Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to \$1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

GENERAL PROVISIONS

Changes to this Certificate – Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Conformity with State Laws – A provision of the Policy and/or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each premium payment after the first premium is paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premium.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 60 days after proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the premiums or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.

ACCIDENT MEDICAL
IN-HOSPITAL ACCIDENT ONLY
ACCIDENTAL DEATH AND DISMEMBERMENT

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of all other causes, from bodily injury which is suffered in an Accident, and occurs while the person is a Covered Person under this Policy and is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

INSURED PERSONS include all members and their lawful spouses under age 70.

Accident means a sudden, unforeseeable external event which causes injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

THIS IS A LIMITED ACCIDENT ONLY INSURANCE, IT IS ACCIDENT ONLY POLICY AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. In order to receive benefits, an insured person must sustain an injury while the policy is in force and such injury directly and independently causes a loss covered by the policy.

Benefits are payable for Eligible Expenses for non-work related injuries on the following basis:

DESCRIPTION OF BENEFITS

BENEFIT AMOUNT: \$25,000

DEDUCTIBLE: \$1,000 PER INJURY

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible as shown above and not to exceed the maximum benefit amount shown therein, all covered expenses incurred within one year from such date.

Covered expenses mean the usual, reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following usual, reasonable and customary charges for treatment, services and supplies provided or prescribed by a Doctor:

(1) Hospital Room & Board, or Surgical Center care and treatment; (2) Outpatient Hospital Emergency room; (3) Surgical Benefits; (4) Doctor's Visits In-Hospital; (5) Doctor Visits Out-Patient; (6) X-ray and Laboratory; (7) Nursing care; (8) Physiotherapy; (9) Ambulance (10) Medical Equipment Rental Charges; (11) Medical Services and Supplies (Blood, Blood transfusions, Oxygen); (12) Prescription Drugs; (13) Dental Treatment as a result of Injury to natural teeth

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: \$50,000

If within one year from the date of an Accident covered under this policy, Injury from such accident results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table. The amount will not exceed the Principal Sum which applies to the Covered Person.

ACCIDENT DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same hand	25%

DISCRIPTION OF HAZARDS

24 Hour Coverage. We will pay the benefits described in this Policy for any Accident which happens to a covered person while he is covered by this Policy. This includes travel or flight in an Aircraft with some restrictions. SEE EXCLUSIONS

GENERAL POLICY PROVISIONS

WORKERS' COMPENSATION INSURANCE: This Policy is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Insurance.

EXCLUSIONS

Benefits will not be paid for a Covered person's loss which:

- (1) Is caused by or results from the Covered Person's own:
 - (a) Intentionally self-inflicted Injury, suicide or any attempt therat. (In Missouri this applies only while sane);
 - (b) Voluntary self administration of any drugs or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
 - (c) Commission or attempt to commit a felony;
 - (d) Participation in a riot or insurrection;
 - (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
 - (f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

- (2) Is caused by or results from:
 - (a) Declared or undeclared war or act of war;
 - (b) An Accident which occurs while the Covered person is on active duty service in any armed forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
 - (c) Aviation, except as specifically provided in this Policy;
 - (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment

bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

- (e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and;
 - (i) The loss was caused by fire, heat, explosion or other physical trauma which was the result of the release of nuclear energy; and
 - (ii) The Covered Person was within a 25 mile radius of the site of the release either:
 - (1) At the time of the release; or
 - (2) Within 24 hours of the start of the release.

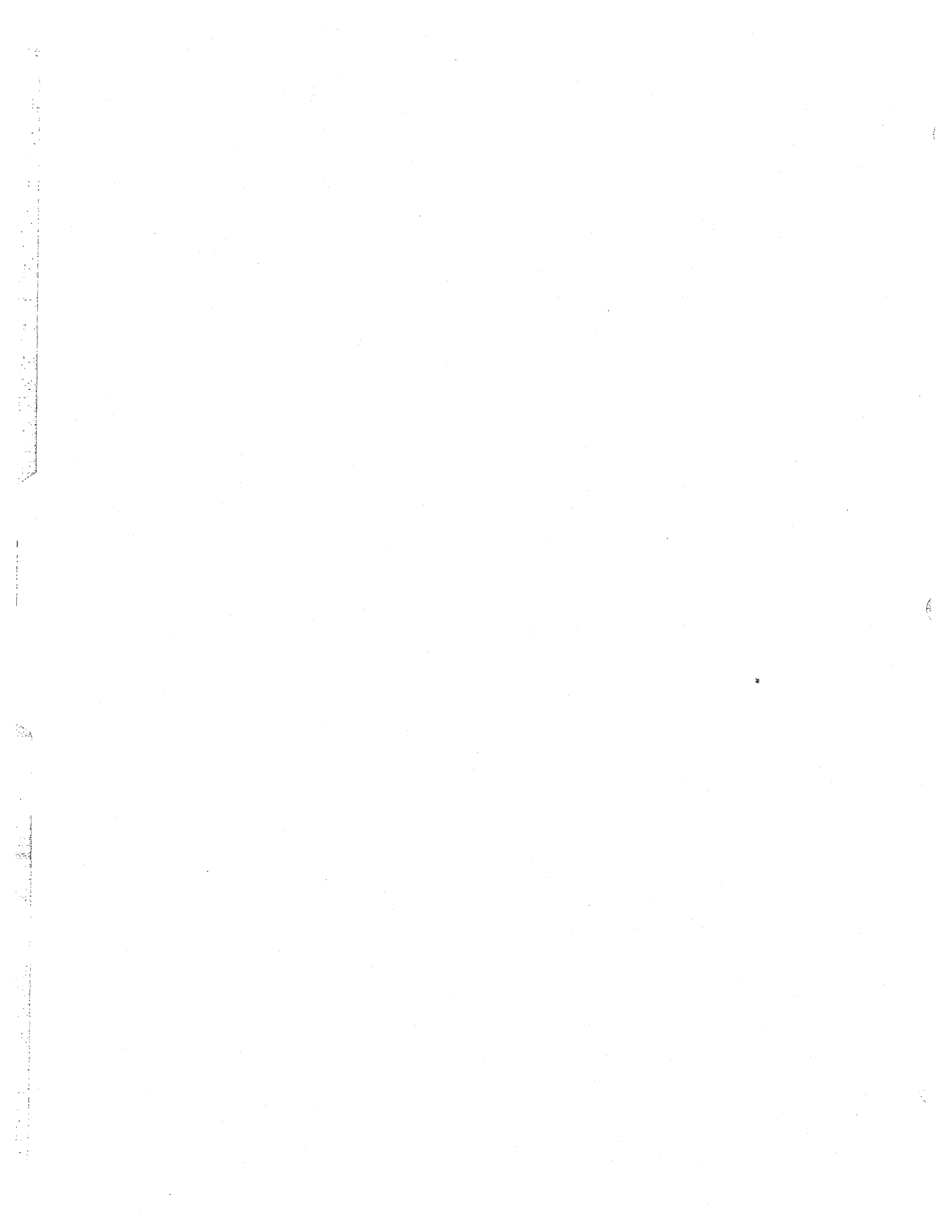
CLAIMS PROVISIONS

Written notice of claim must be given within 30 days after a covered loss occurs or as soon as reasonably possible. We will send forms to authorized members who ask for them.

Notice must be sent to the address below or call 1-800-591-6764

SDS, LLC
4676 HIGHWAY 41 NORTH
SPRINGFIELD, TN. 37172

Underwritten by: SERVE AMERICA, LTD.



AFFIDAVIT

STATE OF TENNESSEE

)

COUNTY OF DAVIDSON

)

I, DURENDA HOOD, being duly sworn, hereby state as follows:

1. I reside at 108 Orchard Valley Circle, Hendersonville, Tennessee 37075-2416.
I am currently unemployed after being laid off from Haskell Steel.
2. In or around October 2008, I purchased health insurance through the American Trade Association (ATA). I contacted ATA after a friend received a fax and forwarded the fax to me. I called the number on the fax and spoke with a sale person. I do not recall who I spoke with and I no longer have the fax.
3. On October 9, 2008, I had \$336.00 deducted from my checking account. Since that time, I have had \$211.00 per month deducted from my checking account to pay for the ATA health insurance premium as evidenced by the attached bank statements. All other details regarding the automatic monthly withdrawals were handled by ATA. The total I have paid for the health insurance is \$3,290.00 (Exhibit 1)
4. After I purchased the health insurance, I received a membership packet from ATA. I also received an insurance card included in the membership packet states claims are sent to SDS in Springfield, Tennessee. The card also said I was part of the Integrated Health Plan. A copy of the card is attached as an exhibit. (Exhibit 2)

5. According to documents in the ATA membership packet, I was supposed to have a limited benefit health insurance plan. The plan said the coverage was underwritten by Serve America, Ltd. The insurance certificate was included in the packet I received from ATA. The packet I received is attached as an exhibit. (Exhibit 3)
6. My doctor's office had never heard of ATA. I never filed a claim for any of my doctor's visits and have never filed a claim on the ATA health insurance.
7. As a member of ATA, I also had access to Express Scripts, a prescription discount plan. The Express Scripts plan has paid some on my prescriptions.
8. As of February 2010, I continue to have the \$211.00 per month premium deducted from my checking account.

Further affiant saith not.

Durenda Hood

Durenda Hood

Sworn to and subscribed before me this 4 day of March, 2010.

Sharon P. Scruggs

Notary Public

My commission expires: 3/19/12



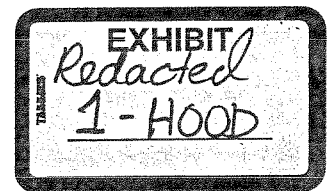
STATEMENT

High Interest Checking

XXX [REDACTED] (Continued)

WITHDRAWALS

Date	Description	Amount
9/26	[REDACTED] [REDACTED] 102 GLEN OATS BLVD HENDERSONVIL TN	[REDACTED]
9/30	PURCHASE [REDACTED] CHECK # [REDACTED]	[REDACTED]
10/01	[REDACTED] 1 [REDACTED] [REDACTED] HENDERSONVILLTN	[REDACTED]
10/01	[REDACTED] 117 INDIAN LAKE BLVD HENDERSONVILLTN	[REDACTED]
10/01	[REDACTED]	[REDACTED]
10/02	[REDACTED] [REDACTED] 1018 AND HENDERSONVILLTN	[REDACTED]
10/02	[REDACTED]	[REDACTED]
10/03	[REDACTED]	[REDACTED]
10/07	[REDACTED]	[REDACTED]
10/09	MEMBERSHIP RBASDS8005916764 PPD	336.00-
10/10	[REDACTED] [REDACTED]	[REDACTED]
10/14	[REDACTED] CHECK [REDACTED] HEND TN	[REDACTED]
10/14	CHECK # [REDACTED]	[REDACTED]
10/15	[REDACTED] [REDACTED] 1376 WAL-SAMS HENDERSONVILLTN	[REDACTED]
10/15	[REDACTED] [REDACTED] 1010 GLENBROOK WY HENDERSONVLLTN	[REDACTED]



CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
10/02	[REDACTED]	[REDACTED]	10/02	[REDACTED]	[REDACTED]

STATEMENT

High Interest Checking

XXXX7201 (Continued)

CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
9/17	2733	-See above-	10/01	2747	-See above-
9/17	2735*	111.70	10/02	2748	-See above-
9/22	2736	91.00	10/06	2749	115.00
9/19	2737	21.30	10/07	2750	58.17
9/22	2738	-See above-	10/07	2751	-See above-
9/24	2739	40.00	10/07	2752	101.25
9/26	2740	105.50	10/08	2753	20.58
9/26	2741	20.81	10/07	2754	59.40
9/26	2742	14.10	10/14	2755	25.00
10/02	2743	45.00	10/14	2757*	-See above-
10/02	2744	337.50	10/15	2758	429.28
10/02	2745	23.81	10/14	2761*	-See above-
9/30	2746	-See above-			

* Denotes missing check numbers

DAILY BALANCE INFORMATION

Date	Balance	Date	Balance	Date	Balance
9/16	[REDACTED]	9/30	[REDACTED]	10/08	[REDACTED]
9/17	[REDACTED]	10/01	[REDACTED]	10/09	[REDACTED]
9/19	[REDACTED]	10/02	[REDACTED]	10/10	[REDACTED]
9/22	[REDACTED]	10/03	[REDACTED]	10/14	[REDACTED]
9/24	[REDACTED]	10/06	[REDACTED]	10/15	[REDACTED]
9/26	[REDACTED]	10/07	[REDACTED]		

INTEREST RATE SUMMARY

Date	Rate
9/15	[REDACTED]

---If applicable, an overdraft fee may be incurred without warning when using another bank's ATM or on any debit card merchant transaction.---

Thank you for banking with us!

STATEMENT

High Interest Checking

XXX [REDACTED] (Continued)

		WITHDRAWALS	
Date	Description		Amount
10/24	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
10/28	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
10/29	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
10/30	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
10/30	[REDACTED]		[REDACTED]
	CHECK [REDACTED]		
	HEND TN		
10/30	[REDACTED]		[REDACTED]
	CHECK # [REDACTED]		
11/03	[REDACTED]		[REDACTED]
	[REDACTED]		
	1010 GLENBROOK WY		
	HENDERSONVILLE TN		
11/03	[REDACTED]		[REDACTED]
	[REDACTED]		
11/03	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
11/06	MEMBERSHIP RBASDS8005916764		211.00-
	PPD		
11/07	[REDACTED]		[REDACTED]
	[REDACTED]		
	HENDERSONVILLE TN		
11/10	[REDACTED]		[REDACTED]
	[REDACTED]		
	[REDACTED]		
	HENDERSONVILLE TN		
11/10	[REDACTED]		[REDACTED]
	CHECK # [REDACTED]		
11/10	[REDACTED]		[REDACTED]
	CHECK [REDACTED]		
11/12	[REDACTED]		[REDACTED]
	CHECK # [REDACTED]		
	HEND TN		

STATEMENT

High Interest Checking

XXXX7201 (Continued)

WITHDRAWALS

Date	Description	Amount
11/14	[REDACTED]	[REDACTED]
	[REDACTED]	
	[REDACTED]	
	[REDACTED]	

CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
10/16	2756	75.00	10/30	2774	-See above-
10/20	2759*	-See above-	10/30	2775	-See above-
10/16	2760	-See above-	11/04	2777*	165.71
10/16	2762*	192.40	11/10	2778	70.00
10/23	2763	50.00	11/10	2779	39.33
10/24	2764	100.00	11/07	2780	103.74
11/04	2765	100.00	11/13	2781	116.54
10/27	2766	70.00	11/07	2782	95.03
10/23	2767	300.00	11/10	2783	-See above-
10/30	2768	107.21	11/10	2784	-See above-
10/28	2769	105.49	11/12	2785	58.24
10/29	2771*	15.58	11/10	2786	140.52
10/30	2772	112.50	11/12	2787	33.75
10/30	2773	-See above-	11/12	2788	-See above-

* Denotes missing check numbers

DAILY BALANCE INFORMATION

Date	Balance	Date	Balance	Date	Balance
10/16	[REDACTED]	10/28	[REDACTED]	11/10	[REDACTED]
10/17	[REDACTED]	10/29	[REDACTED]	11/12	[REDACTED]
10/20	[REDACTED]	10/30	[REDACTED]	11/13	[REDACTED]
10/22	[REDACTED]	11/03	[REDACTED]	11/14	[REDACTED]
10/23	[REDACTED]	11/04	[REDACTED]	11/16	[REDACTED]
10/24	[REDACTED]	11/06	[REDACTED]		
10/27	[REDACTED]	11/07	[REDACTED]		

INTEREST RATE SUMMARY

Date	Rate
10/15	[REDACTED]

---If applicable, an overdraft fee may be incurred without warning when using another bank's ATM or on any debit card merchant transaction.---

Thank you for banking with us!

STATEMENT

High Interest Checking

XXXX7201 (Continued)

WITHDRAWALS

Date	Description	Amount
11/24	[REDACTED] CHECK # [REDACTED] [REDACTED] TN	[REDACTED]
11/25	[REDACTED] [REDACTED]	[REDACTED]
12/01	[REDACTED] [REDACTED]	[REDACTED]
12/02	[REDACTED] [REDACTED]	[REDACTED]
12/02	HENDERSONVIL TN MEMBERSHIP RBASDS8005916764 PPD	211.00-
12/02	[REDACTED] [REDACTED] HEND TN	[REDACTED]
12/03	[REDACTED] [REDACTED]	[REDACTED]
12/03	[REDACTED] [REDACTED]	[REDACTED]
12/05	[REDACTED] CHECK # [REDACTED]	[REDACTED]
12/05	[REDACTED] [REDACTED] [REDACTED]	[REDACTED]
12/09	[REDACTED] [REDACTED] SHELL	[REDACTED]
12/10	[REDACTED] [REDACTED] [REDACTED] [REDACTED] TN	[REDACTED]

CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
12/08	2770	[REDACTED]	12/03	2794	[REDACTED]
11/28	2776*	[REDACTED]	12/02	2795	-See above-
11/21	2789*	-See above-	12/05	2796	[REDACTED]
11/20	2790	-See above-	12/03	2797	-See above-
11/20	2791	-See above-	12/08	2798	[REDACTED]
11/20	2792	[REDACTED]	12/05	2799	-See above-
11/24	2793	-See above-	12/05	2800	[REDACTED]

STATEMENT

High Interest Checking

XXXX7201 (Continued)

		CHECK SUMMARY				
Date	Check No	Amount	Date	Check No	Amount	
12/08	2801	[REDACTED]	12/11	2805*	[REDACTED]	
12/08	2802	[REDACTED]	12/12	2807*	[REDACTED]	
12/11	2803	[REDACTED]	12/11	2809*	[REDACTED]	

* Denotes missing check numbers

DAILY BALANCE INFORMATION					
Date	Balance	Date	Balance	Date	Balance
11/17	[REDACTED]	12/01	[REDACTED]	12/10	[REDACTED]
11/20	[REDACTED]	12/02	[REDACTED]	12/11	[REDACTED]
11/21	[REDACTED]	12/03	[REDACTED]	12/12	[REDACTED]
11/24	[REDACTED]	12/05	[REDACTED]	12/14	[REDACTED]
11/25	[REDACTED]	12/08	[REDACTED]		
11/28	[REDACTED]	12/09	[REDACTED]		

INTEREST RATE SUMMARY	
Date	Rate
11/16	2.000000%

---If applicable, an overdraft fee may be incurred without warning when using another bank's ATM or on any debit card merchant transaction.---

Thank you for banking with us!

STATEMENT

High Interest Checking

XXXX7201 (Continued)

WITHDRAWALS

Date	Description	Amount
12/23	[REDACTED]	[REDACTED]
12/24	[REDACTED]	[REDACTED]
12/24	[REDACTED]	[REDACTED]
12/30	NASHVILLE TN [REDACTED]	[REDACTED]
12/31	[REDACTED]	[REDACTED]
1/05	[REDACTED]	[REDACTED]
1/05	[REDACTED]	[REDACTED]
1/07	[REDACTED]	[REDACTED]
1/08	MEMBERSHIP RBASDS8005916764 PPD	211.00-
1/08	[REDACTED]	[REDACTED]
1/09	PURCHASE [REDACTED] CHECK # [REDACTED] HEND TN	[REDACTED]
1/13	CHECK [REDACTED] CHECK # [REDACTED]	[REDACTED]
1/13	CHECK [REDACTED] CHECK # [REDACTED]	[REDACTED]

CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
12/15	2804	134.12	12/23	2814*	-See above-
12/15	2806*	187.60	12/23	2815	111.70
12/16	2810*	488.51	1/09	2816	146.93
12/16	2811	-See above-	12/30	2817	109.31
12/18	2812	26.26	12/30	2818	90.16

STATEMENT

High Interest Checking

XXXX7201 (Continued)

CHECK SUMMARY

Date	Check No	Amount	Date	Check No	Amount
12/29	[REDACTED]	[REDACTED]	1/09	[REDACTED]	[REDACTED]
12/23	[REDACTED]	[REDACTED]	1/09	[REDACTED]	[REDACTED]
1/05	[REDACTED]	[REDACTED]	1/09	[REDACTED]	-See above-
12/31	[REDACTED]	[REDACTED]	1/13	[REDACTED]	-See above-
12/31	[REDACTED]	-See above-	1/13	[REDACTED]	-See above-
1/09	[REDACTED]	[REDACTED]	1/13	[REDACTED]	[REDACTED]
1/09	[REDACTED]	[REDACTED]	1/13	[REDACTED]	[REDACTED]

* Denotes missing check numbers

DAILY BALANCE INFORMATION

Date	Balance	Date	Balance	Date	Balance
1/05	[REDACTED]	12/15	[REDACTED]	12/24	[REDACTED]
1/07	[REDACTED]	12/16	[REDACTED]	12/29	[REDACTED]
1/08	[REDACTED]	12/18	[REDACTED]	12/30	[REDACTED]
1/09	[REDACTED]	12/22	[REDACTED]	12/31	7 [REDACTED]
1/13	[REDACTED]	12/23	[REDACTED]		

INTEREST RATE SUMMARY

Date	Rate
[REDACTED]	[REDACTED]

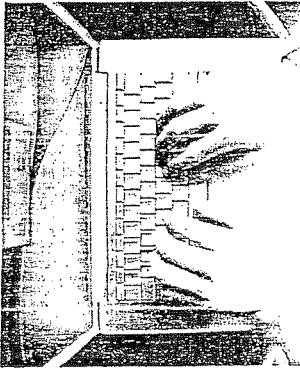
---If applicable, an overdraft fee may be incurred without warning when using another bank's ATM or on any debit card merchant transaction.---

Thank you for banking with us!

Account Number	XX [REDACTED]
Date	6/12/09
Current Balance	[REDACTED]
Page	1 of 6

3475 2 AT 0.482 *0003475 S5
DURENDA HOOD
[REDACTED]

Under the FDIC's Transaction Account Guarantee Program, funds in non-interest bearing checking accounts are now fully insured by the FDIC. Funds in, swept into, or transferred into interest bearing accounts are now insured up to \$250,000.



eStatements

www.greenbankusa.com

Many customers are concerned about identity theft and fraud. eStatements allow you to retrieve your statements from your home or office computer. It's free, safe, and convenient. No more personal information sitting in your mailbox. Sign up today by calling 800-639-5111 or 1-800-639-5111.

CHECKING ACCOUNT

High Interest Checking		Previous Balance	[REDACTED]
Account Number	XXXXXX [REDACTED]	1 Deposits/Credits	[REDACTED]
Statement Dates	5/14/09 thru 6/14/09	50 Checks/Debits	[REDACTED]
Days in the Statement Period	[REDACTED]	Service Charge	[REDACTED]
Annual Percentage Yield Earned	[REDACTED]	Interest Paid This Statement	[REDACTED]
2009 Interest Paid	[REDACTED]	Current Balance	[REDACTED]

Deposits and Additions

Date	Description	Amount
6/09	Deposit	[REDACTED]
6/14	Interest Deposit	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
5/15	[REDACTED]	[REDACTED]
5/15	[REDACTED]	[REDACTED]
5/19	[REDACTED]	[REDACTED]
5/20	[REDACTED]	[REDACTED]



Checks and Withdrawals (continued)

Date	Description	Amount
5/26	[REDACTED]	[REDACTED]
5/26	[REDACTED]	[REDACTED]
5/26	[REDACTED]	[REDACTED]
5/26	[REDACTED]	[REDACTED]
5/26	[REDACTED]	[REDACTED]
5/27	[REDACTED]	[REDACTED]
5/27	[REDACTED]	[REDACTED]
5/29	[REDACTED]	[REDACTED]
5/29	[REDACTED]	[REDACTED]
6/01	[REDACTED]	[REDACTED]
6/01	[REDACTED]	[REDACTED]
6/01	[REDACTED]	[REDACTED]
6/01	[REDACTED]	[REDACTED]
6/01	[REDACTED]	[REDACTED]
6/03	MEMBERSHIP RBASDS8005916764 PPD	211.00-
6/04	[REDACTED]	[REDACTED]
6/05	[REDACTED] 3512 W H NASHVILLE TN	[REDACTED]
6/05	[REDACTED]	[REDACTED]
6/05	[REDACTED]	[REDACTED]
6/08	[REDACTED]	[REDACTED]
6/09	[REDACTED]	[REDACTED]
6/09	[REDACTED]	[REDACTED]
6/09	[REDACTED]	[REDACTED]
6/09	[REDACTED]	[REDACTED]
6/12	[REDACTED]	[REDACTED]

Summary by Check Number

Date	Number	Amount	Date	Number	Amount
5/19	2919	402.50	5/21	2930	162.00
5/19	2922*	160.00	6/01	2931	25.00
5/15	2923	-See above-	5/26	2932	28.25
5/19	2924	-See above-	5/26	2933	-See above-
5/19	2925	29.55	6/01	2934	349.70
5/21	2926	109.32	6/01	2935	200.00
5/27	2927	203.00	6/01	2936	-See above-
5/19	2928	29.48	6/01	2937	61.99
5/22	2929	50.00	6/01	2938	-See above-

* Denotes missing check numbers

Account Number	XXXXX [REDACTED]
Date	7/14/09
Current Balance	[REDACTED]
Page	1 of 6

3437 2 AT 0.482 *0003437 S4
DURENDA HOOD
[REDACTED]
[MICR LINE]

Under the FDIC's Transaction Account Guarantee Program, funds in non-interest bearing checking accounts are now fully insured by the FDIC. Funds in swept into, or transferred into interest bearing accounts are now insured up to \$250,000.



CHECKING ACCOUNT

High Interest Checking	Account Number XXXXX [REDACTED]	Previous Balance	[REDACTED]
Statement Dates 6/15/09 thru 7/14/09	Days in the Statement Period 30	4 Deposits/Credits	[REDACTED]
Annual Percentage Yield Earned [REDACTED]	2009 Interest Paid [REDACTED]	43 Checks/Debits	[REDACTED]
		Service Charge	[REDACTED].00
		Interest Paid This Statement	[REDACTED]
		Current Balance	[REDACTED]

Deposits and Additions

Date	Description	Amount
6/19	Deposit	[REDACTED]
6/22	Deposit	[REDACTED]
6/29	Deposit	[REDACTED]
7/13	Deposit	[REDACTED]
7/14	Interest Deposit	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
6/16	[REDACTED]	[REDACTED]
6/16	[REDACTED]	[REDACTED]

Checks and Withdrawals (continued)

Date	Description	Amount
6/22	[REDACTED]	[REDACTED]
6/23	[REDACTED]	[REDACTED]
6/23	[REDACTED]	[REDACTED]
6/23	[REDACTED]	[REDACTED]
6/24	[REDACTED]	[REDACTED]
6/24	[REDACTED]	[REDACTED]
6/25	[REDACTED]	[REDACTED]
6/30	[REDACTED]	[REDACTED]
7/01	[REDACTED]	[REDACTED]
7/01	[REDACTED]	[REDACTED]
7/03	[REDACTED]	[REDACTED]
7/03	[REDACTED]	[REDACTED]
7/06	[REDACTED]	[REDACTED]
7/06	[REDACTED]	[REDACTED]
7/06	[REDACTED]	[REDACTED]
7/06	[REDACTED]	[REDACTED]
7/07	[REDACTED]	[REDACTED]
7/07	[REDACTED]	[REDACTED]
7/08	MEMBERSHIP RBASDS8005916764 PPD	211.00-
7/09	[REDACTED]	[REDACTED]
7/09	[REDACTED]	[REDACTED]
7/10	DBT 4647	[REDACTED]
7/13	[REDACTED]	[REDACTED]

Look for credit

Summary by Check Number

Date	Number	Amount	Date	Number	Amount
6/17	[REDACTED]	[REDACTED]	6/30	[REDACTED]	[REDACTED]
6/15	[REDACTED]	[REDACTED]	6/29	[REDACTED]	[REDACTED]
6/16	[REDACTED]	[REDACTED]	7/02	[REDACTED]	[REDACTED]
6/16	[REDACTED]	-See above-	7/01	[REDACTED]	-See above-
6/16	[REDACTED]	[REDACTED]	7/06	[REDACTED]	[REDACTED]
6/26	[REDACTED]	[REDACTED]	7/03	[REDACTED]	-See above-
6/19	[REDACTED]	[REDACTED]	6/30	[REDACTED]	-See above*
6/23	[REDACTED]	[REDACTED]	7/02	[REDACTED]	[REDACTED]
6/26	[REDACTED]	[REDACTED]	6/30	[REDACTED]	[REDACTED]

* Denotes missing check numbers

Account Number	XXXXXX [REDACTED]
Date	8/13/09
Current Balance	[REDACTED]
Page	1 of 5

3414 1 AT 0.357 *0003414 53
DURENDA HOOD
[REDACTED]
[MICR LINE]

Under the FDIC's Transaction Account Guarantee Program, funds in non-interest-bearing checking accounts are now fully insured by the FDIC. Funds in, swept into, or transferred into interest-bearing accounts are now insured up to \$250,000.



CHECKING ACCOUNT

High Interest Checking	Account Number XXXXX [REDACTED]	Previous Balance	[REDACTED]
Statement Dates 7/15/09 thru	[REDACTED]	4 Deposits/Credits	[REDACTED]
Days in the Statement Period	[REDACTED]	47 Checks/Debits	[REDACTED]
Annual Percentage Yield Earned	[REDACTED]	Service Charge	[REDACTED]
2009 Interest Paid	[REDACTED]	Interest Paid This Statement	[REDACTED]
		Current Balance	[REDACTED]

Deposits and Additions

Date	Description	Amount
7/20	[REDACTED]	[REDACTED]
7/20	[REDACTED]	[REDACTED]
7/29	[REDACTED]	[REDACTED]
8/03	[REDACTED]	[REDACTED]
8/13	[REDACTED]	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
7/15	[REDACTED]	[REDACTED]
7/15	[REDACTED]	[REDACTED]



Member FDIC
MSI REV 1 2/09 GREENBANK-STMT

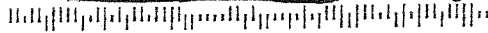
Customer Service: 800-639-5111

Checks and Withdrawals (continued)		Amount
------------------------------------	--	--------

Date	Description	Amount
7/16	[REDACTED]	[REDACTED]
7/16	[REDACTED]	[REDACTED]
7/17	[REDACTED]	[REDACTED]
7/20	[REDACTED]	[REDACTED]
7/20	[REDACTED]	[REDACTED]
7/21	[REDACTED]	[REDACTED]
7/22	[REDACTED]	[REDACTED]
7/22	[REDACTED]	[REDACTED]
7/22	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/27	[REDACTED]	[REDACTED]
7/28	[REDACTED]	[REDACTED]
7/30	[REDACTED]	[REDACTED]
7/31	[REDACTED]	[REDACTED]
8/03	[REDACTED]	[REDACTED]
8/03	[REDACTED]	[REDACTED]
8/03	[REDACTED]	[REDACTED]
8/04	[REDACTED]	[REDACTED]
8/04	[REDACTED]	[REDACTED]
8/05	[REDACTED]	[REDACTED]
8/06	MEMBERSHIP ATASDS8005916764 PPD	211.00-
8/06	[REDACTED]	[REDACTED]
8/07	[REDACTED]	[REDACTED]
8/07	[REDACTED]	[REDACTED]

Account Number	XXXXXX [REDACTED]
Date	9/14/09
Current Balance	[REDACTED]
Page	1 of 6

3441 2 AT 0.482 *0003441 S4
DURENDA HOOD [REDACTED]



Under the FDIC's Transaction Account Guarantee Program, funds in non-interest bearing checking accounts are now fully insured by the FDIC. Funds in, swept into, or transferred into interest bearing accounts are now insured up to \$250,000.



- Safe
- Easy
- Stylish

CHECKING ACCOUNT

High Interest Checking		
Account Number	XXXXXX [REDACTED]	Previous Balance
Statement Dates	8/14/09 thru 9/14/09	5 Deposits/Credits
Days in the Statement Period	[REDACTED]	42 Checks/Debits
Annual Percentage Yield Earned	[REDACTED]	Service Charge
2009 Interest Paid	[REDACTED]	Interest Paid This Statement
		Current Balance

Deposits and Additions

Date	Description	Amount
8/14	Deposit	[REDACTED]
8/26	Deposit	[REDACTED]
9/02	Deposit	[REDACTED]
9/09	Deposit	[REDACTED]
9/11	Deposit	[REDACTED]
9/14	Interest Deposit	[REDACTED]



Checks and Withdrawals		
------------------------	--	--

Date	Description	Amount
8/18	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]
8/20	[REDACTED]	[REDACTED]
8/24	[REDACTED]	[REDACTED]
8/25	[REDACTED]	[REDACTED]
9/01	[REDACTED]	[REDACTED]
9/01	[REDACTED]	[REDACTED]
9/02	MEMBERSHIP ATASDS8005916764 PPD	211.00-
9/02	[REDACTED]	[REDACTED]
9/02	[REDACTED]	[REDACTED]
9/04	[REDACTED]	[REDACTED]
9/04	[REDACTED]	[REDACTED]
9/04	[REDACTED]	[REDACTED]
9/04	[REDACTED]	[REDACTED]
9/04	[REDACTED]	[REDACTED]
9/08	[REDACTED]	[REDACTED]
9/08	[REDACTED]	[REDACTED]
9/08	[REDACTED]	[REDACTED]
9/09	[REDACTED]	[REDACTED]
9/09	[REDACTED]	[REDACTED]
9/11	[REDACTED]	[REDACTED]

Summary by Check Number					
-------------------------	--	--	--	--	--

Date	Number	Amount	Date	Number	Amount
8/19	[REDACTED]	[REDACTED]	8/26	[REDACTED]	[REDACTED]
8/24	[REDACTED]	[REDACTED]	8/28	[REDACTED]	[REDACTED]
8/19	[REDACTED]	[REDACTED]	8/28	[REDACTED]	[REDACTED]
8/19	[REDACTED]	-See above-	8/24	[REDACTED]	[REDACTED]
8/18	[REDACTED]	[REDACTED]	9/01	[REDACTED]	-See above-
8/18	[REDACTED]	-See above-	9/02	[REDACTED]	[REDACTED]
8/24	[REDACTED]	[REDACTED]	9/01	[REDACTED]	-See above-
8/24	[REDACTED]	[REDACTED]	9/09	[REDACTED]	[REDACTED]
8/24	[REDACTED]	[REDACTED]	9/08	[REDACTED]	-See above-

* Denotes missing check numbers

Account Number	XXXXXX [REDACTED]
Date	10/14/09
Current Balance	[REDACTED]
Page	1 of 5

3300 1 AT 0.357 *0003300 S3
DURENDA HOOD
[REDACTED]
[MICR LINE]

GreenBank participates in the FDIC's TAG Program. Funds in non-interest bearing accounts are fully insured by the FDIC regardless of amount thru 6/30/10. Funds in interest-bearing accounts are insured up to \$250,000 per depositor thru 12/31/13.



Free Internet Banking

Bank Online...anytime, anywhere

Check your account balances, transfer funds, make loan payments, pay bills, stop payments, review statements, order checks, set up alerts, and more! Sign up today!

CHECKING ACCOUNT

High Interest Checking	Account Number	XXX [REDACTED]	Previous Balance	[REDACTED]
Statement Dates	9/15/09 thru	[REDACTED]	2 Deposits/Credits	[REDACTED]
Days in the Statement Period		[REDACTED]	37 Checks/Debits	[REDACTED]
Annual Percentage Yield Earned		[REDACTED]	Service Charge	[REDACTED]
2009 Interest Paid		[REDACTED]	Interest Paid This Statement	[REDACTED]
			Current Balance	[REDACTED]

Deposits and Additions

Date	Description	Amount
9/24	Deposit	[REDACTED]
10/13	Deposit	[REDACTED]
10/14	Interest Deposit	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
9/16	[REDACTED]	[REDACTED]
9/17	[REDACTED]	[REDACTED]
9/18	[REDACTED]	[REDACTED]



MSI REV 12/09 GREENBANK-STMT

Customer Service: 800-639-5111

Checks and Withdrawals (continued)

Date	Description	Amount
1018	[REDACTED]	[REDACTED]
9/18	[REDACTED]	[REDACTED]
9/22	[REDACTED]	[REDACTED]
9/23	[REDACTED]	[REDACTED]
9/24	[REDACTED]	[REDACTED]
9/25	[REDACTED]	[REDACTED]
9/28	[REDACTED]	[REDACTED]
9/29	[REDACTED]	[REDACTED]
10/05	[REDACTED]	[REDACTED]
10/05	[REDACTED]	[REDACTED]
10/05	[REDACTED]	[REDACTED]
10/05	[REDACTED]	[REDACTED]
10/06	[REDACTED]	[REDACTED]
10/07	MEMBERSHIP ATASDS8005916764 PPD	211.00-
10/08	[REDACTED]	[REDACTED]
10/09	[REDACTED]	[REDACTED]
10/13	[REDACTED]	[REDACTED]
10/13	[REDACTED]	[REDACTED]
10/13	[REDACTED]	[REDACTED]
10/14	[REDACTED]	[REDACTED]
10/14	POS HWY [REDACTED]	[REDACTED]

Summary by Check Number

Date	Number	Amount	Date	Number	Amount
9/15	[REDACTED]	[REDACTED]	10/02	[REDACTED]	[REDACTED]
9/15	[REDACTED]	[REDACTED]	10/06	[REDACTED]	[REDACTED]
9/18	[REDACTED]	-See above-	10/05	[REDACTED]	[REDACTED]
9/17	[REDACTED]	[REDACTED]	10/05	[REDACTED]	-See above-
9/23	[REDACTED]	[REDACTED]	10/08	[REDACTED]	[REDACTED]
9/24	[REDACTED]	[REDACTED]	10/09	[REDACTED]	[REDACTED]
9/30	[REDACTED]	[REDACTED]	10/08	[REDACTED]	-See above-
9/30	[REDACTED]	[REDACTED]	10/09	[REDACTED]	-See above-
9/29	[REDACTED]	-See above-	10/13	[REDACTED]	[REDACTED]
10/09	[REDACTED]	[REDACTED]	10/14	[REDACTED]	-See above-

* Denotes missing check numbers

Account Number	XXXXX [REDACTED]
Date	11/12/09
Current Balance	[REDACTED]
Page	1 of 1

3324 2 AT 0.482 *0003324 S4
DURENDA HOPE
[REDACTED]
[MICR LINE]

GreenBank participates in the FDIC's
TAG Program. Funds in non-interest
bearing accounts are fully insured by
the FDIC regardless of amount thru
6/30/10. Funds in interest-bearing
accounts are insured up to \$250,000
per depositor thru 12/31/13.



Free Internet Banking

Bank Online...anytime, anywhere

Check your account balances, transfer funds,
make loan payments, pay bills, stop payments,
review statements, order checks, set up alerts,
and more! Sign up today!

CHECKING ACCOUNT

High Interest Checking Account Number Statement Dates 10/15/09 thru Days in the Statement Period	XXXX [REDACTED]	Previous Balance 3 Deposits/Credits 48 Checks/Debits Service Charge Interest Paid This Statement Current Balance	[REDACTED]
Annual Percentage Yield Earned 2009 Interest Paid	[REDACTED]		[REDACTED]

Deposits and Additions

Date	Description	Amount
11/02	Deposit	[REDACTED]
11/04	[REDACTED]	[REDACTED]
11/09	Deposit	[REDACTED]
11/12	Interest Deposit	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
10/16	[REDACTED]	[REDACTED]
10/19	[REDACTED]	[REDACTED]

Member FDIC
MSI REV 12/09 GREENBANK-STMT

Customer Service: 800-639-5111

Checks and Withdrawals (continued)

Date	Description	Amount
10/20	[REDACTED]	[REDACTED]
10/21	[REDACTED]	[REDACTED]
10/21	[REDACTED]	[REDACTED]
10/22	[REDACTED]	[REDACTED]
10/22	[REDACTED]	[REDACTED]
10/23	[REDACTED]	[REDACTED]
10/27	[REDACTED]	[REDACTED]
10/28	[REDACTED]	[REDACTED]
10/29	[REDACTED]	[REDACTED]
11/02	[REDACTED]	[REDACTED]
11/02	[REDACTED]	[REDACTED]
11/02	[REDACTED]	[REDACTED]
11/02	[REDACTED]	[REDACTED]
11/03	[REDACTED]	[REDACTED]
11/03	[REDACTED]	[REDACTED]
11/04	[REDACTED]	[REDACTED]
11/04	MEMBERSHIP ATASDS8005916764 PPD	211.00-
11/04	[REDACTED]	[REDACTED]
11/04	[REDACTED]	[REDACTED]
11/04	[REDACTED]	[REDACTED]
11/05	[REDACTED]	[REDACTED]
11/05	[REDACTED]	[REDACTED]
11/05	[REDACTED]	[REDACTED]
11/06	[REDACTED]	[REDACTED]
11/06	[REDACTED]	[REDACTED]
11/09	[REDACTED]	[REDACTED]
11/12	[REDACTED]	[REDACTED]

Account Number	XXXXX [REDACTED]
Date	12/14/09
Current Balance	[REDACTED]
Page	1 of 5

3282 1 AT 0.357 *0003282 03
DURENDA HOOD
[REDACTED]
[MICR LINE]

GreenBank participates in the FDIC's TAG Program. Funds in non-interest bearing accounts are fully insured by the FDIC regardless of amount thru 6/30/10. Funds in interest-bearing accounts are insured up to \$250,000 per depositor thru 12/31/13.



**FIRST TIME HOMEBUYERS
& REPEAT HOMEBUYERS**
may be eligible for the extended
HOMEBUYER TAX CREDIT!
Ask at your branch, call 888-670-9421
or go to www.greenbankusa.com to find
the Mortgage Specialist in your area.

CHECKING ACCOUNT

High Interest Checking		Previous Balance	[REDACTED]
Account Number	XXXXX [REDACTED]	3 Deposits/Credits	[REDACTED]
Statement Dates	11/13/09 thru 12/14/09	49 Checks/Debits	[REDACTED]
Days in the Statement Period	[REDACTED]	Service Charge	[REDACTED]
Annual Percentage Yield Earned	[REDACTED]	Interest Paid This Statement	[REDACTED]
2009 Interest Paid	[REDACTED]	Current Balance	[REDACTED]

Deposits and Additions

Date	Description	Amount
12/02	Deposit	[REDACTED]
12/07	Deposit	[REDACTED]
12/11	Deposit	[REDACTED]
12/14	Interest Deposit	[REDACTED]

Checks and Withdrawals

Date	Description	Amount
11/13	[REDACTED]	[REDACTED]
11/13	[REDACTED]	[REDACTED]



Checks and Withdrawals (continued)		
------------------------------------	--	--

Date	Description	Amount
11/17	[REDACTED]	[REDACTED]
11/19	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/23	[REDACTED]	[REDACTED]
11/24	[REDACTED]	[REDACTED]
11/25	[REDACTED]	[REDACTED]
11/27	[REDACTED]	[REDACTED]
11/30	[REDACTED]	[REDACTED]
11/30	[REDACTED]	[REDACTED]
11/30	[REDACTED]	[REDACTED]
12/01	[REDACTED]	[REDACTED]
12/02	MEMBERSHIP ATASDS8005916764 PPD	211.00-
12/02	[REDACTED]	[REDACTED]
12/03	[REDACTED]	[REDACTED]
12/03	[REDACTED]	[REDACTED]
12/03	[REDACTED]	[REDACTED]
12/04	[REDACTED]	[REDACTED]
12/04	[REDACTED]	[REDACTED]
12/08	[REDACTED]	[REDACTED]
12/08	[REDACTED]	[REDACTED]
12/09	[REDACTED]	[REDACTED]
12/09	[REDACTED]	[REDACTED]
12/10	[REDACTED]	[REDACTED]
12/14	[REDACTED]	[REDACTED]

Account Number	XXXXX [REDACTED]
Date	2/08/10
Current Balance	[REDACTED]
Page	1 of 5

3178 1 AT 0.357 *0003178 S2
DURENDA HOOD
[REDACTED]
[REDACTED]

In March 2010, most checks will be deemed to be local checks when processed. This means that if a hold is placed on a check that you deposit, the held funds may be made available for use more quickly depending upon the type of hold placed.



**FIRST TIME HOMEBUYERS
& REPEAT HOMEBUYERS**
may be eligible for the extended
HOMEBUYER TAX CREDIT!

Ask at your branch, call 888-670-9421
or go to www.greenbankusa.com to find
the Mortgage Specialist in your area.

CHECKING ACCOUNT

High Interest Checking		
Account Number	XXXXX [REDACTED]	Previous Balance
Statement Dates 1/11/10 thru	[REDACTED]	4 Deposits/Credits
Days in the Statement Period	[REDACTED]	45 Checks/Debits
	[REDACTED]	Service Charge
Annual Percentage Yield Earned	[REDACTED]	Interest Paid This Statement
2010 Interest Paid	[REDACTED]	Current Balance

Deposits and Additions

Date	Description	Amount
1/19	[REDACTED]	[REDACTED]
2/01	[REDACTED]	[REDACTED]
2/01	[REDACTED]	[REDACTED]
2/08	Deposit	[REDACTED]
2/08	Interest Deposit	[REDACTED]



Checks and Withdrawals		
------------------------	--	--

Date	Description	Amount
1/11	[REDACTED]	[REDACTED]
1/12	[REDACTED]	[REDACTED]
1/12	[REDACTED]	[REDACTED]
1/12	[REDACTED]	[REDACTED]
1/14	[REDACTED]	[REDACTED]
1/14	[REDACTED]	[REDACTED]
1/19	[REDACTED]	[REDACTED]
1/19	[REDACTED]	[REDACTED]
1/21	[REDACTED]	[REDACTED]
1/21	[REDACTED]	[REDACTED]
1/22	[REDACTED]	[REDACTED]
1/22	[REDACTED]	[REDACTED]
1/22	[REDACTED]	[REDACTED]
1/22	[REDACTED]	[REDACTED]
1/25	[REDACTED]	[REDACTED]
1/25	[REDACTED]	[REDACTED]
1/25	[REDACTED]	[REDACTED]
1/26	[REDACTED]	[REDACTED]
1/26	[REDACTED]	[REDACTED]
1/28	[REDACTED]	[REDACTED]
2/01	[REDACTED]	[REDACTED]
2/01	[REDACTED]	[REDACTED]
2/02	[REDACTED]	[REDACTED]
2/03	[REDACTED]	[REDACTED]
2/03	[REDACTED]	[REDACTED]
2/05	[REDACTED]	[REDACTED]
2/08	[REDACTED]	[REDACTED]
2/08	Healthplan Healthplan PPD	211.00-

add Back

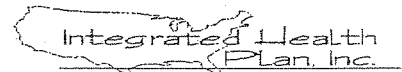


Express Scripts
RxBIN: 003858 RxPCN: A4 RGRP: ZZ31

Insured Name:
DURENDA HOOD

ATA HEALTH PLAN Effective Date: 10/1/2008
Coverage: MEMBER ONLY
Group No: ATA211
Member ID NO: I6844H39007

For Member Rx Service call: 800-451-6245
Pharmacist Use Only: 800-824-0898

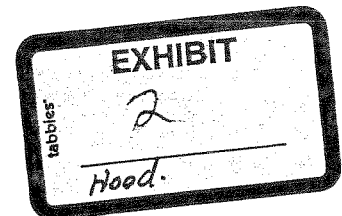


Go To: www.inplan.com
To Find a Network Provider
Provider Inquiry:

Mail Medical Claims To:
SDS
4676 Hwy 41 N.
Springfield, TN 37172

1-888-640-8707

All customer service, billing and claim inquiries call 800-591-6764.





Welcome to the ATA! We are very pleased to have you join our Association. It is made up of people just like you. Hard working American's that have joined together to create buying power and to help promote and support the American way of life.

Enclosed you will find information on a number of ancillary benefits that come to you as a member of our Association. If you decided to purchase our optional Limited Benefit Health Plans you will be receiving your materials shortly. You will receive your fulfillment packages round the first week of your plan being active. You will receive a package containing your ID cards (two if you added your spouse or children to the plan, one if it is just you on the program). Also in the package will be a copy of your policy with all the benefits listed and explained and also information on all the other exciting benefits that come along with your ATA membership.

Your RX/Dental and Vision cards will come to you directly from the provider and should arrive very shortly if they have not already gotten to you.

Our website can help answer many of the questions you may have about how the plans and benefits work. The address is www.atafirst.com. On the site there are links to most of the providers. From using Integrated health Plan www.IHPlan.com to help locate network providers, to MedSave for Pharmacy and prescription information and helping you find vendors and services for our non-insurance benefits as well. Spend a few minutes roaming around and check out the numerous great benefits that come along with your new membership package.

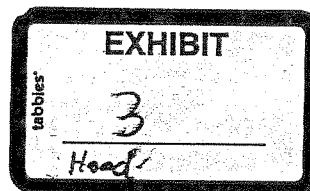
Our Customer Service staff stands ready to answer any question that is not on the website or you have a problem finding. Our number is 800-591-6764 and it is answered live from 8:00 AM to 5:00 PM central time Monday through Thursday and from 8:00 AM to 3:00 PM on Fridays.

Emergency admissions will be verified the following business day.

Again, thank you for joining our ever growing family and we look forward to serving your needs for many years to come.

Best Regards,

American Trade Association





FREQUENTLY ASKED QUESTIONS

1. Is this major medical insurance? - NO, this policy is considered as Limited Benefit Insurance and is not intended to replace Major Medical Coverage. Please read the outline carefully to understand the benefits. This applies to both the mini-medical plans as well as the per occurrence plans. The only plan that we offer that can be considered major medical coverage is the catastrophic plan with either a \$10,000 or \$20,000 deductible and then coverage to \$250,000 a year and \$1 million lifetime. Many people use the limited benefit plans to pay first dollar benefits to offset the high deductible plan.
2. Is the coverage guarantee issued? - You must be an eligible member of the Association to have the plan guaranteed issue for your group or business. To be eligible for Association membership you must be employed at the time the policy is issued and you must be either an Employer, Employee, Independent Contractor or self-employed and under the age of 65.
3. Are there pre-existing clauses or wait times for benefits? - This varies by plan. With the limited benefit mini-medical plans as long as you are an eligible member of the Association the plan is issued with no pre-existing exclusionary periods. The only exception is there is a thirty day waiting period for the Critical Illness benefit offered as part of the Premier 1000 plan. All other benefits are available immediately after the effective date of coverage. The Per-Occurrence plans are guarantee issue as long as you are an eligible member of the Association but carry a 12 month pre-existing condition limitation unless you have current creditable coverage and then depending on the time you have been covered the pre-existing can be waived. Check the Plan benefit information page for the exact terms and conditions. The same is true of the catastrophic plan. It has a 12 month pre-existing limitation and has the same requirement for having it waived.
4. Who is eligible for the plan? You must be at work on the day the plan becomes effective. You must either be an independent contractor, a business owner or work for a business as a full or part-time employee or contractor. You must be a member of the American Trade Association. You must not be disabled or unable to work due to health conditions at the time the plan goes into effect.
5. Does the plan cover me on the job? You are covered for any sickness, illness or accident that is NOT job related. No on the job injury or sickness is covered under the benefits of this plan.
6. Do I have to go to a particular doctor or provider? No, you are free to go to any doctor or provider of your choice. However, the plan is contracted with Integrated Health Plans, (www.ihplan.com). To locate a provider use User name SDS and Password SDS2008 to access network listing and if you use providers and hospitals that are members of this network any discounts for services will be passed on to you which will allow the indemnity benefit paid by the plan to go further in paying your medical expenses.
7. When is the effective date? Effective dates are always the 1st of the month. If we receive your application and first month's premium or your Company sends in an electronic enrollment form and premium prior to the 25th of the month your effective date will be the 1st of the next month. If received after the 25th your effective date will be the 1st of the following month. Any exceptions must be approved by Home Office prior to receipt of the applications.
8. Are the Discount Benefits and Non-Insurance Benefits included in the rates? Yes they are all included and are part of the Association package. For the cost of the insurance only portion of the plan contact your agent directly.



PPO Re-pricing

What you may not know about your medical bills. All medical bills are re-priced. Most insurance companies hope that your deductible and co-pay will cover the cost of your doctor's visit or hospital stay. Insurance companies enter into agreements with various PPO Networks for a predetermined price on all surgical procedures, daily hospital rates, physician services, lab fees, etc. In other words, the insurance provider pays based on wholesale rates and they enjoy the savings. The good news for all Acloche employees, we get the same discount pricing they do but we pass those savings on to you rather than keep them ourselves.

We are affiliated with Integrated Health Plans PPO who has thousands of doctors and hospitals who are participants. You will be able to access their network nationwide via the web at www.IHPlan.com and enter user name SDS, password SDS2008 to locate provider or by calling our Customer Service to help you locate a provider in your area.



When you have to go to a doctor or hospital, you will need to verify they are still active in your network in order to receive the best pricing.

The PPO's logo will be on your card to verify membership in that network. Your membership guarantees that you will be paid what your indemnity plan states regardless of who you see, but if you see doctors or go to a hospital within the PPO listed on your card, you will be able to take advantage of the pre-arranged re-pricing, and your out-of-pocket expenses may be less.

If you have any question regarding your plan, or need assistance in locating a provider near you please contact us:

Office 1-800-591-6764

FAX 1-615-382-9594

www.IHPlan.com



As a member of the American Trade Association your association has negotiated a contract with Quest Diagnostics and its affiliate Lab One to allow you access to their lab services at a discounted rate off their National Billing Schedule.

TO TAKE BET ADVANTAGE OF THIS PROGRAM PLEASE FOLLOW THE INSTRUCTIONS OUTLINED BELOW:

1. TELL YOUR PHYSICIAN THAT YOUR HEALTH PLAN HAS A DIRECT CONTRACT WITH QUEST AND LAB ONE FOR LAB TESTS AND THE SAVINGS ARE 50% TO 75% OFF RETAIL SO YOU WOULD LIKE TO USE ONE OF THESE LABS FOR YOUR TESTS. IF THE DOCTOR CURRENTLY USES ONE OF THESE TWO COMPANIES FOR THEIR LAB WORK ASK IF YOU CAN BE BILLED DIRECTLY BY THE LAB COMPANY. IF HE SAYS YES, HAVE THE TESTS DONE THERE, IF NOT ASK HIM FOR A PRESCRIPTIONS TO QUEST OR LAB ONE FOR THE TESTS HE WANTS DONE.
2. EITHER CONTACT OUT CUSTOMER SERVICE DEPARTMENT FOR HELP IN LOCATING THE NEAREST LAB FACILITY OR GO ONLINE TO WWW.QUESTDIAGNOSTICS.COM TO FIND A LAB AND SET AN APPOINTMENT.
3. MAKE SURE YOU HAVE YOUR HEALTH INSURANCE CARD WITH YOU WHEN YOU GO FOR YOUR APPOINTMENT AND HAVE THE LAB BILL YOU DIRECTLY AND SEND THE CLAIMS TO OUR CLAIMS PROCESSER AT THE ADDRESS LISTED ON YOUR CARD.
4. YOUR TESTS WILL BE RE-PRICED AND YOU WILL SEE AN AVERAGE OF A 50% TO 70% SAVINGS ON YOUR LAB WORK.

Customer Service can be reached at
1-800-591-6764

Monday – Thursday 8:00 AM to 5:00 PM Central
Friday 8:00 AM to 3:00 Central

Sample Discounts (Taken from actual claims)

Cholesterol Test CPT82465	Retail Price \$24.00.....	ATA Member Price - \$2.00
MGB, Glycated CPT 83036	Retail Price \$62.25.....	ATA Member Price - \$11.25
Thyroxine Free CPT84439	Retail Price \$111.30.....	ATA Member Price - \$13.25
Triglycerides CPT94478	Retail Price \$32.30.....	ATA Member Price - \$8.50
Prostate Specific AG CPT84153	Retail Price \$119.79.....	ATA Member Price - \$18.00
CBC, PLT,DIFF CPT85025	Retail Price \$36.75.....	ATA Member Price- \$8.25
HCG (QN) CPT84702	Retail Price \$103.20.....	ATA Member Price- \$9.50

Discounts May Vary by area of the country





Welcome to the World of Prescription Dental and Vision Savings

As a American Trade Association member, you can use your cards to save on the cost of Dental Services and Vision Services. Present the card to any of our providers to get our special discounted or co-pay pricing.

Dental Services Powered by DenteMax: Access to more than 81,000 access points nationwide. All DenteMax dentists agree to charge members using a fixed fee schedule that is typically 25-40% below their usual charges. This provides savings for you and your family every time you visit your DenteMax dentist. To find a provider and information on fee schedules go to www.dentemax.com

Vision Services Powered by Outlook: All vision services at an average savings of 10% - 50% for our members through the Outlook Provider network. More than 11,500 locations nationwide. Take full advantage of discounts on frames, lenses and contacts. Special discounts on eye exams and lasik surgery at select locations. To locate a provider and samples of savings go to www.outlookvision.com



Member Name: Jack Smith
Group: ATA2522
Member ID: 654851
ATA Member Service 800-591-6764

This is Not Insurance



EXPRESS SCRIPTS®

ATA/RBA Co-Pay Prescription Program

Per Occurrence Plans

As a member of the American Trade Association/RBA enrolled in the Serve America Per Occurrence Health Plan you also have included a prescription program through Express Scripts.

You will enjoy prescription benefits at less than wholesale rates for all your medicine requirements.

Founded in 1986 and never owned by a drug manufacturer, Express Scripts aligns its interests with those of plan sponsors and their members. This legacy of independence means that the company's programs and original research on the pharmacy benefit serve its clients.

Express Scripts drives to lowest net cost by enabling better health and value at the consumer level. As evidence, Express Scripts' generic dispensing rate leads the industry.

Express Scripts is accepted at all the major drug store chains and most larger grocery stores as well as many of the larger independent drug stores in rural America. Kroger, HEB, Wal-Mart, Sam's, Costco, CVS, Drug Emporium, Walgreens, Publix, Winn-Dixie, Target, Revco, Randall's, Rite Aide.

Your benefit plan is explained in the certificate package that is included with your membership cards but the plan pays a 50% co-pay of the net cost of the medication up to an annual maximum per member. Beyond that maximum the plan becomes a discount program for medications.

All discounts are done at the counter and no claims need to be filed. You pay 50% of the net cost for the drugs and the insurance carrier pays the balance. If you have questions about your plan or how the benefit works you can call Express Scripts directly at 1-800-451-6245. If your pharmacist has questions he may call Express Scripts at 1-800-824-0898.

Also remember Express Scripts offers further discounted mail order pharmacy for your maintenance medication needs

SDS CUSTOMER SERVICE

800-591-6764

The Hertz logo is displayed in a stylized, italicized font within a dark, rectangular background that has a slightly distressed or metallic texture.

YOU HOLD THE KEY TO A WORLD OF BENEFITS FROM HERTZ

Planning a family vacation or any out-of-town business trip? If your plans include renting a car, then take advantage of a special membership savings and service from Hertz.

At Hertz, you will find time saving options like Computerized Driving Directions, Hertz Never Lost, Express Return, 24 hour roadside assistance. And whether you need a compact, full-size or specialty vehicle, Hertz offers a wide variety of new cars to handle your rental needs.

Hertz also makes sure you're enjoying special worldwide savings. As an ATA member you will receive discounts off your rentals in the U.S. and around the world. The key to your savings is your Hertz discount CDP#1739263. Just mention this number when making your reservation. Then present your membership card or Hertz Member Discount Card at the time of your rental. It is that easy!

For reservations and information call your travel agent or Hertz "Members Only" toll free number: 1-800-654-2200 or visit www.hertz.com.

Introducing a New Member Benefit from Hertz.

Now when you rent from Hertz you can take advantage of a special year-round savings through the Hertz Member Benefit Program. ATA members receive a discount off Hertz Daily Member rates, Hertz US Standard Rates; and Hertz US Leisure Rates. You'll be quoted the best rate for your rental needs at the time of reservation.

With Approximately 7,000 locations in more than 150 countries, Hertz is able to offer you special discounts on your rentals in Canada, Europe and worldwide Call Hertz for Details.

For reservations and information call Hertz "Members Only" toll free number at 1-800-654-2200 and mention your Hertz Discount CDP#1739263. Present your membership card or Hertz Member Discount Card at the time of rental.



GULFSTREAM FINANCIAL CORPORATION is the only Company in America to offer an independent and end-to-end program for Financial Liability Portfolio Management (the "program") that includes technology, fulfillment/processing support and plan execution. The Program reliably liquidates all financial liabilities including mortgages in approximately 8 1/2 years with no compromise in credit standing or increase in monthly payments. This includes balances on: credit cards, car loans, credit union and bank loans, IRS liabilities, student loans and the mortgages completely eliminated without increasing monthly expense. Interest savings are substantial and the Program improves the client's credit rating. The Program represents an inherent and sustaining value proposition to clients by eliminating all creditor obligations quickly and predictably.

Clients experience the Program as automatic and passive. In a short time they enjoy zero liabilities; they own their home outright, and with no more outlay than they were committing to service their financial obligations prior to enrollment. After graduation from the Program, with the liability portfolio retired, clients are more capable of building an asset portfolio and planning for their golden years.

There is no out of pocket expense for Program enrollment.

This is neither credit counseling or debt consolidation nor debt negotiation.

For more information and to speak with a Financial Services Representative, contact 1-888-221-0548 or go online to: www.iono1.com. Tell the counselor you are a member of the American Trade Association.

you have just entered the

MORTGAGEZONE



MORTGAGE & REALTY ASSISTANCE PROGRAM

The ATA has partnered with Mortgage Zone to offer our members assistance in mortgage planning and realtor services. This plan offers cash rewards when members purchase or refinance their homes and obtain a mortgage through Mortgage Zone. You can choose from over 250 lenders to give you the best options and payment. This program is a "members only" plan for both you and your extended family members that use the purchasing power of the American Trade Association, Inc. to offer better rates and significant rebates to its members.

You, and through your membership in ATA, your family members, sons, daughters and grandchildren can benefit from this program. You get cash rewards for your family member, not just yourself, when they obtain a mortgage from Mortgage Zone.

Here is how to access the Mortgage Zone Assistance Program:

Step 1 - go to https://33aff.mzbe.com/public/short_app_form.php to begin the no cost enrollment

Step 2 - Enter your name, email address, phone number

Step 3 - within 24 hours a service representative will call you and discuss your goals

OR - Call 1-877-693-0287 and we can answer any questions and help get you started.

ROS

RETIRE ON SPENDING

COMPLIMENTS OF ATA

As a gift to you, American Trade Association Inc is providing a complimentary membership to Retire on Spending (ROS) - which gives cash back on internet shopping at over 1,000 merchants - you can save up to 17% over retail, plus get cash back on all your purchases - from mainline merchants like Wal-Mart, Old Navy, and Target, clothing sites for cool clothes, music specific sites where you can get the latest MP3, IPOD's and other music related items, and over 1,000 other sites. Saving money on all the things you will need - plus other benefits. This helps ATA promote its activities, so everyone wins.

Retire on Spending is here for you now.

You will get a free replicated ROS member web site that contains your very own private "Smart-Mart and back-office, plus a monthly allowance of \$50.00 in SMART-CASH. Each time you shop in any of the approximately 1,000 of America's favorite stores in your SMART-Mart, you're Smart-Cash is automatically converted into real cash and ROS mails you a check for up to \$50.00 a month!

For your convenience, no user name, or pin account or ID# or special password, or special procedure is required. It's simple, all you have to do is login to your personal website and click on "shopping" and ROS's unique, proprietary system will recognize that the transaction is originating from your "Smart-Mart.

To join "Free", go to www.retireonspending.com

Serve America, LTD

Administrative Office
SDS
4676 Highway 41 North
Springfield, TN. 37172

This Certificate explains the Limited Group Hospital Indemnity Insurance that is underwritten by Serve America, LTD. Please read it closely to be familiar with your coverage.

Terms important in understanding the Certificate are defined in the Definitions section or in separate Certificate Provisions and are capitalized in this Certificate.

Important Notice - Benefits are payable as described in this Certificate for accidents or sickness that are incurred while the Covered person is insured under the Group Master Policy ("Policy")

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to periodic changes.

The insurance made under this Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are insured and you have applied for coverage for each of your dependents. Such applications must be approved by Us, and the required premium paid for each dependent.

Policyholder: American Trade Association

Governing Jurisdiction: Arkansas

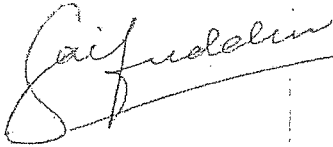
Policy Number: ATAI111

Insured:

Certificate Number:

Effective Date:

Signed for the Company at Our Home Office to take effect on the Certificate Effective Date.



President

CERTIFICATE FOR LIMITED GROUP HOSPITAL INDEMNITY INSURANCE

**LIMITED BENEFIT - READ YOUR CERTIFICATE CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS**

TABLE OF CONTENTS

<u>CERTIFICATE SECTIONS</u>	<u>PAGES</u>
SCHEDULE OF BENEFITS	3
DEFINITIONS	4
ELIGIBILITY AND EFFECTIVE DATE	5
BENEFIT PROVISIONS	6
EXCLUSIONS AND LIMITATIONS	7
PREMIUMS	8
TERMINATION OF INSURANCE	8
CLAIMS PROVISION	9
GENERAL PROVISIONS	10

SCHEDULE OF BENEFITS

INSURED:	CERTIFICATE NUMBER:
AGE AT ISSUE:	DEPENDENT COVERAGE:
INSURED EFFECTIVE DATE:	DEPENDENT EFFECTIVE DATE:
ANNUAL MAXIMUM BENEFIT LIMIT:	NONE

BENEFIT COVERAGE

EFFECTIVE DATE:	TYPE OF COVERAGE PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY AMOUNT BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER CONFINEMENT	\$500
DAILY INDEMNITY BENEFIT FOR CONFINEMENT IN AN INTENSIVE CARE OR CRITICAL CARE IN-PATIENT ROOM BENEFIT AMOUNT PER DAY: MAXIMUM OF 30 DAYS PER YEAR PER MEMBER	\$500
IN-HOSPITAL & IN-PATIENT ADDITIONAL HOSPITAL INDEMNITY BENEFIT PER ADMISSION PER MEMBER: MAXIMUM VISITS PER YEAR PER MEMBER:	\$500 2
SURGICAL AND ANESTHESIA INDEMNITY BENEFIT BENEFIT FOR SURGERY PER SURGICAL VISIT AS LISTED IN THE TABLE OF SURGICAL INDEMNITY BENEFIT SCHEDULE: BENEFIT FOR ANESTHESIA PER SURGICAL VISIT	\$1,000 SCHEDULE EQUAL TO 20% OF SURGICAL BENEFIT AMOUNT
OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT BENEFIT AMOUNT PER OFFICE VISIT: MAXIMUM NUMBER OF OFFICE VISITS PER YEAR PER MEMBER:	\$50 6
OFF-THE-JOB ACCIDENT INJURY BENEFIT MAXIMUM BENEFIT: MAXIMUM NUMBER PER YEAR PER MEMBER:	\$500 5
OUTPATIENT DIAGNOSTIC X-RAY & LAB INDEMNITY BENEFIT BENEFIT AMOUNT PER VISIT PER MEMBER: CALENDAR YEAR MAXIMUM VISITS PER MEMBER:	\$50 4

EFFECTIVE
DATE:

TYPE OF COVERAGE
PER COVERED PERSON

**EMERGENCY ROOM SICKNESS BENEFIT INDEMNITY
BENEFIT**

BENEFIT AMOUNT PAID PER ER VISIT FOR SICKNESS
OR ILLNESS: \$50
MAXIMUM NUMBER OF VISITS PER YEAR: 2

WELLNESS INDEMNITY BENEFIT

BENEFIT AMOUNT PER VISIT PER MEMBER: \$50
MAXIMUM CALENDAR YEAR VISITS PER MEMBER: 1
WELL CHILD VISITS - 4 VISITS PER YEAR PER CHILD
FROM 0 MONTHS TO 12 MONTHS
WELL CHILD VISITS - 2 VISITS PER YEAR PER CHILD
FROM 12 MONTHS TO 24 MONTHS

**DAILY IN-PATIENT DRUG & ALCOHOL INDEMNITY
BENEFIT**

BENEFIT PER DAY OF CONFINEMENT IF INSURED:
IS CONFINED IN A REHABILITATION FACILITY \$300
FOR SUBSTANCE ABUSE
ANNUAL MAXIMUM BENEFIT: \$10,000
LIFETIME MAXIMUM OF \$30,000

**DAILY IN-PATIENT MENTAL & NERVOUS INDEMNITY
BENEFIT**

BENEFIT PER DAY OF CONFINEMENT IF INSURED:
IS CONFINED IN A REHABILITATION FACILITY \$300
FOR MENTAL OR NERVOUS DISORDERS
ANNUAL MAXIMUM BENEFIT: \$10,000
LIFETIME MAXIMUM OF \$30,000

EXPRESS SCRIPTS RX CARD BENEFIT

Insured prescription card - AWP less 16% discount
Then an 50% copay per prescription up to an annual
Benefit per member of \$500 then an Express Scripts
Discount plan beyond there - no pre-existing exclusions \$500

**GROUP TERM LIFE INSURANCE POLICY WITH ACCIDENTAL
DEATH AND DISMEMBERMENT RIDER ATTACHED**

PRIMARY MEMBER BENEFIT: \$5,000
SPOUSE: \$2,500
CHILD(REN) - NOT COVERED FOR AD&D BENEFIT \$2,500

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and of this Certificate:

Accident or Accidental Injury: a sudden, unexpected and unintended injury:

- This is independent of any Sickness; and
- That is caused by or the result of external means; and
- That takes place while the Covered person's coverage is in force.

Active Service: You are:

- Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; and
- Those duties are performed at your place of business where You normally do such duties or at some location to which your employer sends you.

You are said to be in Active Service on a day which is not a scheduled work day only if You would be able to perform in the usual manner all of the regular duties of Your occupation if it were a scheduled work day, and You were in Active Service on the last preceding regular work day.

Amendment, Endorsement or Rider: Any form issued by Us which adds, modifies, changes or deletes any Policy or Certificate provisions or benefits.

Application or Enrollment Form: The form completed and signed to apply for this insurance coverage.

Calendar year or Year: The period from January 1 through December 31 of the same year.

Certificate: The document that describes your hospital indemnity insurance coverage.

Child: A child of Yours who is unmarried; under the age of 19; dependent upon you for more than 50% of his/her support and maintenance; who lives with You; and is:

- A natural Child; or
- A legally adopted Child or a Child who has been placed for adoption with you; or
- A stepchild or foster Child; or
- A child for whom You have been appointed legal guardian; or
- A Child not living with You, but for whom you are legally required to provide support.

"Child" also includes a Child who meets the criteria described above, but who is age 19 or older, if the Child is:

- A full-time student at an accredited educational institution, college, university, vocational institution, trade school, or secondary institution, and is under the age of 24; or
- Becomes incapable of self-support because of mental retardation or physical impairment while insured, and prior to reaching the limiting age of a Child. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time, but no more often than once a year after the Child attains the age of 24.

The term "Child" does not include a child who engages in any employment or business for compensation, profit or gain for 30 or more hours per week, unless such child is a full-time student as described above.

Confinement or Confined: That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

Covered Person: Any or all of the following: You, Your Spouse or Your Children, who has been accepted by Us for coverage.

Critical Illness: Any of the following conditions:

1. Cancer – A disease which is identified by the presence of a malignant tumor characterized by uncontrolled growth and spread of malignant cells, and the invasion of normal tissue. Cancer must be positively identified and diagnosed with histopathological conformation. Leukemia and Hodgkin's disease (except stage 1 Hodgkin's disease) will be considered Cancer.
 - Cancer does not include
 - Pre-Malignant conditions or conditions with malignant potential;
 - Prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1 (b), or of other equivalent or lesser classifications).
2. Skin Cancer – Basal cell epithelioma or squamous cell carcinoma. Skin cancer does not include malignant melanoma or mycosis fungoides.
3. Carcinoma in situ – Cancer that is diagnosed with histopathological confirmation and confined to the site of the origin without having invaded neighboring tissue.
4. Heart Attack [the death (infarction) of a portion of heart muscle as a result of inadequate blood supply. The diagnosis must be based on all of the following criteria:
 - a) Associated new electrocardiographic (EKG) changes consistent with Injury;
 - b) Elevation of Cardiac enzymes; and
 - c) Confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
5. Stroke – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage or embolizations of brain tissue from an extracranial source. The diagnosis must be based on:
 - Documented neurological deficits; and
 - Confirmatory neuron-imaging studies

Stroke does not include cerebral symptoms due to:

- Transient ischemic attack (TIA);
 - Reversible neurological deficit;
 - Migraine;
 - Cerebral injury resulting from trauma or hypoxia; or
 - Vascular disease affecting the eye, optic nerve or vestibular functions.
6. End Stage Renal Failure – Chronic, irreversible failure of the function of both kidneys, such that a Covered person must undergo regular hemodialysis or peritoneal dialysis at least weekly.
 7. Major Organ Transplant Surgery – A Covered person undergoing surgery as a recipient of a human to human transplant of a heart, lung, kidney or pancreas.

Dependent – Your Child or Spouse as defined by the Certificate

Disability or Disabled – The inability, due to an injury or sickness to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child or Spouse: "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Effective Date – The date coverage is in effect is shown on the Schedule of Benefits. The effective date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability – The correct and complete answers to the questions in the Application of Enrollment Form and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered person.

Grace Period – The period of 31 days allowed for each premium payment after the first premium.

Group Master Policy or Policy: The complete contract of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to insureds, including any Amendments, Endorsement, Riders, Applications or Enrollment Forms signed by the Policyholder and each insured.

Policyholder – The entity named on the Cover Page of the Policy

Hospital – A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly Licensed Physicians.

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians.
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician.
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

The term "Hospital" does not include any institution used by the Covered Person as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Immediate Family Member – You, Your Spouse, Child, mother, father, brother, sister or other close family member of the Covered person.

Injury or Off-the-Job injury - An injury which is caused by an Accident, and does not occur while in the course of any legal or illegal occupation, activity or employment for pay, benefit or profit.

Insured – The employee or member covered for this insurance and named on the Cover page of this Certificate,

Intensive Care Unit – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned to it on a full-time basis; and
2. Be under the full-time direction and/or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life saving equipment.

Intensive Care Unit includes: Intensive cardiac and coronary care units, neonatal intensive care units, and burn intensive care units if such units meet the conditions in this definition. This does not include any lesser treatment units.

Physician – A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an immediate Family member.

Pre-Existing Condition – A Sickness or physical condition for which the Covered person:

1. Had treatment;
2. Incurred Expense;
3. Took medications; or
4. Received a Diagnosis or advice from a Physician.

During the 12 month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-existing" will also include a condition that manifests itself in a way that would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Schedule of Benefits or Schedule – The benefit schedule set forth in this Certificate.

Sickness – An illness or disease which first manifests itself while the Covered person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse named in the Application or Enrollment Form. If you are not legally married, "Spouse" may include your common law spouse if named in the Application or Enrollment Form and if legally recognized in the state in which you reside.

Testing Day – The day on which one or more diagnostic X-rays or laboratory tests are performed.

Waiting Period – The period of time from your date of employment or membership that must expire before you are eligible to enroll for coverage, as specified in the Policyholder's Application.

We, Us, or Our – The Insurer that underwrites this coverage: Serve America, LTD

You, Your, or Yours – The Insured.

ELIGIBILITY AND EFFECTIVE DATE

Effective dates are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective dates for all persons added to coverage after this Certificate is issued will be shown on the Schedule of Benefits issued at the time of the addition.

Employer or Member Eligibility – To be eligible for insurance You must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Satisfactorily answer all eligibility and other questions on the Application or Enrollment Form and must provide evidence of Insurability satisfactory to us, if we ask for it; and
3. Be Actively at work. Either as a business owner, independent contractor, work for a small business or a member of a workers union.

Employee or Member Effective Date – Your insurance will take effect on the Effective Date of the Policy if:

1. You completed an Application or Enrollment Form on or before the effective date; and
2. You are in Active Service; and
3. Your first premium is paid and received by Us.

If you are not eligible for this coverage on the Policy effective date, Your coverage will take effect on the first day of the day which coincides with or next follows the date You first become eligible and are approved for coverage. Additionally, Your first premium must have been received by Us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

If you are disabled on what otherwise would be the effective date, Your coverage will be deferred until the first of the month following the date you cease to be disabled.

Dependent Eligibility – If Dependent coverage is available, A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he/she first meets the definition of Dependent.

You may elect dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the dependent becomes eligible; and
2. Completing any required forms for payroll deduction or drafting of your account for payment

You must complete an Application for Enrollment of a Spouse or Child, and pay any required premium within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31 day period Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a covered person on your effective date may be added to this Certificate subject to:

1. The Completion of an Application or Enrollment Form;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If you and your spouse are both eligible as an employee or member, the Children may be insured as Dependents of either You or your Spouse but not both

Dependent Effective Date – The effective date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application or Enrollment Form; and
2. Our receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the effective date for dependent coverage will be the same as your effective date.

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise be in effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

Newborn Child Effective Date – A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, so long as your coverage is in force on that date. Coverage includes premature babies, congenital defects and birth abnormalities. The Dependent newborn child's coverage will not continue past the 31 day period following the date of birth, unless:

1. You have notified Us by the end of the 31 day period of the addition of such newborn Child, and
2. You have paid any applicable additional premium.

BENEFIT PROVISIONS

Subject to the provisions of this certificate, and any maximum benefit limitations stated on the schedule of benefits, we will pay a benefit for a covered loss that occurs while the covered person is insured under the policy, subject to extension of Benefits Provision. Please see the Schedule of Benefits for the benefit amount details for each benefit listed below.

Daily In-Hospital Indemnity Benefit – If a Covered Person is confined in a hospital as a result of Accident or Sickness, We will pay the benefit amount per day shown on the schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Surgical and Anesthesia Indemnity Benefit – If a Covered Person undergoes a surgical procedure listed on the Table of Surgical Indemnity Benefits Schedule ("Surgical Table"), which is attached to this Certificate, as a result of a covered Accident or Sickness, We will pay the benefit shown on that Surgical table. We will also pay the benefit amount, if shown on the Schedule of Benefits, for the administration of anesthesia per surgical visit by a Physician in connection with the surgery.

If two or more procedures are performed through the same incision or operative field, the benefit paid will be for only the procedure that has the larger benefit. If more than one procedure is performed, but each through a separate incision or in the separate operative field, the amount payable will be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Representative surgeries have been listed in the Surgical Table. A complete Surgical Schedule has been filed with the State. We will pay all surgeries in accordance with that Surgical Schedule. With respect to surgical procedures that are not listed in the Surgical Schedule, We will pay an indemnity benefit that is consistent with similar procedures within the Surgical Schedule.

Outpatient Physician Office Visit Indemnity Benefit – We will pay this benefit as shown on the Schedule for a physician office visit as a result of an Accident or Sickness.

Off-the-Job Accidental Injury Benefit - We will pay benefits for the actual charges incurred for a covered Accident up to the amount shown on the Schedule for each Covered Person, for x-rays used to diagnose an Accidental Injury and treatment of a covered accident by a Physician in the Physician's office, clinic, or urgent care facility or Hospital emergency room. Treatment must be received within 72 hours of such Accident for benefits to be payable. For purpose of this benefit only, "actual charges" will mean the amount actually paid by or on behalf of the Covered Person and accepted by a Hospital or Physician for services provided.

Critical Illness Indemnity Benefit – The Critical Illness Indemnity Benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this certificate. A Benefit is payable for any one of the following:

Critical Illness – We will pay the amount shown on the Schedule for each Covered Person when he/she is first diagnosed as having a covered Critical Illness.

Skin Cancer – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed with Skin cancer.

Carcinoma In Situ – We will pay the amount specified on the Schedule for each Covered Person when he/she is first diagnosed as having Carcinoma In Situ.

BENEFIT PROVISIONS (Continued)

Subsequent Critical Illness Indemnity Benefit – We will pay this benefit, in the amount specified on the Schedule of Benefits, when a Covered Person is first diagnosed as having a subsequent and separate covered Critical Illness. The subsequent Critical Illness must be a Critical Illness that is defined in a separate category of conditions than the first covered Critical Illness; the subsequent and separate covered Critical Illness must first manifest itself, and be diagnosed more than 60 days after the first covered Critical Illness is initially diagnosed. This subsequent Critical Illness benefit is payable only one time for each Covered Person, and will be paid in addition to any other benefit in this Certificate. This subsequent Critical Illness Benefit is not payable for Carcinoma In Situ or Skin Cancer.

Wellness Indemnity Benefit – We will pay this benefit as shown on the Schedule for each Covered Person who has undergone the following: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Intensive Care Indemnity Benefit – If a Covered Person is confined in an Intensive Care Unit as a result of Accident or Sickness, We will pay the benefit amount per day shown on the Schedule. Each day must include an overnight stay for which a Hospital charge is made. No benefit will be paid for any day the Covered Person is not under the regular care and attendance of a Physician.

Benefits When There is a Break in Service – If a covered Person's coverage terminates for any reason, and such person is re-enrolled for coverage as either an employee/member or Dependent under this Policy or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy, all benefits paid during the Calendar Year will be accumulated and applied towards the maximum benefit for the Calendar Year as described on the Schedule of Benefits, no matter how many times a Covered Person becomes insured under this or any other Transamerica Life Insurance Company Group Hospital Indemnity Insurance Policy.

Physical Examinations and Autopsy – We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

Proof of Loss – Satisfactory written Proof of Loss must be given to Us at Our Administrative Office. In case of a claim for loss for which a period payment is provided contingent upon continuing loss, each satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of said loss. Satisfactory written proof of loss includes but is not limited to: itemized Physician or Hospital bills, and, with regard to Critical Illness benefits, the initial pathology report diagnosing a Critical Illness.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the date of loss, unless the claimant was legally incapacitated.

Time of Payment of Claims – benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

EXCLUSIONS AND LIMITATIONS

With respect to all the benefits provided under this Certificate, no benefits will be payable as the result of:

1. Suicide or any attempt thereof, while sane or insane;
2. Any Intentional self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment (unless provided as a benefit on the Schedule of Benefits);
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings (unless the Wellness Indemnity Benefit is shown the Schedule of Benefits);
5. Routine newborn care (unless covered under the Wellness Indemnity Benefit on the Schedule of Benefits);
6. The treatment of:
 - a. Mental illness, functional or organic nervous disorder, regardless of cause (unless the Daily In-Patient Mental and Nervous Benefit is shown the Schedule of Benefits);
 - b. Alcohol abuse or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed (unless the Daily In-Patient Drug and Alcohol Benefit is shown the Schedule of Benefits);
7. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
8. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
9. Participation in:
 - a. An organized contest of speed;
 - b. Parachuting;
 - c. Parasailing;
 - d. Bungee Jumping; or
 - e. Hang Gliding;
10. Air travel, except:
 - a. As a fare-paying passenger on a commercial airline on a regularly scheduled route; or,
 - b. As a passenger for transportation only and not as a pilot or crew member;
11. Any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred);
12. Any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
13. The reversal of a tubal ligation or vasectomy;
14. Artificial insemination, in vitro fertilization, and test tube fertilization, including an relate testing, medications or Physician's services, unless required by law;
15. Any loss incurred while on active duty status in the armed forces (if You notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as result of this exception.);
16. Accident or Sickness arising out of and in the course of any occupation for compensation, wage or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
17. Air or ground ambulance transportation (unless the Ambulance Benefit is shown on the Schedule);
18. Routine eye examinations or fitting of eye glasses;
19. Hearing aids or fitting of hearing aids;
20. Dental examinations or dental care other than expenses resulting from an Accident;
21. Care or treatment of an Accident or Sickness not specifically provided for in this plan;
22. With respect to the Off-the-Job Accidental Injury Benefit only, charges that the Covered Person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
23. Treatment of an Accident or Sickness made necessary by or arising from war, declare or undeclared, or any act of war.

PREMIUMS

All premiums are payable on or before the date they are due. You must pay any required contribution to the Policyholder.

We have the right to change the premium rates on any premium due in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder. If an increase takes place on other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due the coverage will automatically be terminated as of the date the pro rate premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increase Our liability, premium rates may be changed on the date that Our liability is increased, without regard to any premium rate guarantee.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which You can cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to Us;
3. The date the policy terminates; or
4. The last day of the payroll deduction period during which You terminate employment.
- 5.

The Insurance on a Dependent will cease on the earliest of:

1. The date Your coverage terminates;
2. The end of the last period for which premium payment has been made to Us;
3. The date of the Dependent no longer meets the definition of Dependent; or
4. The date the Policy is modified so as to exclude Dependent coverage.
- 5.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Extension of Benefits - Whenever termination of coverage under this section occurs due to the termination of Your employment or membership such termination will be without prejudice to:

1. Any Hospital Confinement which commenced while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits; or
2. Any covered treatment or service for which benefits would be provided and which commenced while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confine or Disabled.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer disabled.

CLAIMS PROVISIONS

Claim Forms - Claims forms should be used for filing Proof of Loss. We will send such form to claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, You can give proof in writing, setting for the nature and extent of loss within the time stated in the Proof of Loss Provision.

Claims Procedure - Due Proof of Loss must be submitted to us at our administrative Office. You or a personal representative may obtain a claim form by calling Our toll-free telephone number listed on the Cover Page.

Notice of Claim - Written notice of claim must be given to Us at Our Administrative Officer, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to delay.

Payment of Benefits - Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your estate. We may pay up to \$1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment fully discharges Us to the extent of the payment.

GENERAL PROVISIONS

Changes to this Certificate – Only Our President, Vice-President, Secretary or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy of this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Conformity with State Laws – A provision of the Policy and/or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

Entire Contract – The entire Contract consists of the Policy, the Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, Your Applications and any Enrollment forms.

Grace period – A grace period of 31 days will be allowed for each premium payment after the first premium is paid. Coverage will stay in force during this period. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premium.

Legal Action – No legal action may be brought to recover under the Policy and or Certificate:

1. Within 60 days after proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age – If the covered person's age has been misstated, the covered persons true age will be used to adjust the premiums or adjust the benefits paid.

No Dividends Payable – This Certificate does not participate in the profits or surplus earnings of Our Company.

Right to Contest – We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the effective date of coverage. Any such statement would have to be in a signed form. This also applies to all riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

When Notice is Given to Us – Any notice to You will be sent to your last known address.

ACCIDENT MEDICAL
IN-HOSPITAL ACCIDENT ONLY
ACCIDENTAL DEATH AND DISMEMBERMENT

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a covered loss which is within the scope of the DESCRIPTION OF BENEFITS PROVISIONS and results, directly and independently of all other causes, from bodily injury which is suffered in an Accident, and occurs while the person is a Covered Person under this Policy and is within the scope of the risks set forth in the DESCRIPTION OF HAZARDS provisions.

INSURED PERSONS include all members and their lawful spouses under age 70.

Accident means a sudden, unforeseeable external event which causes injury to one or more Covered Persons and occurs while coverage is in effect for the Covered Person.

THIS IS A LIMITED ACCIDENT ONLY INSURANCE, IT IS ACCIDENT ONLY POLICY AND DOES NOT COVER LOSS OR EXPENSE RESULTING FROM SICKNESS, DISEASE, OR BODILY INFIRMITY. In order to receive benefits, an insured person must sustain an injury while the policy is in force and such injury directly and independently causes a loss covered by the policy.

Benefits are payable for Eligible Expenses for non-work related injuries on the following basis:

DESCRIPTION OF BENEFITS

BENEFIT AMOUNT: \$25,000

DEDUCTIBLE: \$1,000 PER INJURY

If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible as shown above and not to exceed the maximum benefit amount shown therein, all covered expenses incurred within one year from such date.

Covered expenses mean the usual, reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following usual, reasonable and customary charges for treatment, services and supplies provided or prescribed by a Doctor:

(1) Hospital Room & Board, or Surgical Center care and treatment; (2) Outpatient Hospital Emergency room; (3) Surgical Benefits; (4) Doctor's Visits In-Hospital; (5) Doctor Visits Out-Patient; (6) X-ray and Laboratory; (7) Nursing care; (8) Physiotherapy; (9) Ambulance (10) Medical Equipment Rental Charges; (11) Medical Services and Supplies (Blood, Blood transfusions, Oxygen); (12) Prescription Drugs; (13) Dental Treatment as a result of Injury to natural teeth

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum: \$50,000

If within one year from the date of an Accident covered under this policy, Injury from such accident results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table. The amount will not exceed the Principal Sum which applies to the Covered Person.

ACCIDENT DEATH, DISMEMBERMENT, OR LOSS OF SIGHT

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger of the Same hand	25%

DISCRIPTION OF HAZARDS

24 Hour Coverage. We will pay the benefits described in this Policy for any Accident which happens to a covered person while he is covered by this Policy. This includes travel or flight in an Aircraft with some restrictions. SEE EXCLUSIONS

GENERAL POLICY PROVISIONS

WORKERS' COMPENSATION INSURANCE: This Policy is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Insurance.

EXCLUSIONS

Benefits will not be paid for a Covered person's loss which:

- (1) Is caused by or results from the Covered Person's own:
 - (a) Intentionally self-inflicted Injury, suicide or any attempt therat. (In Missouri this applies only while sane);
 - (b) Voluntary self administration of any drugs or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
 - (c) Commission or attempt to commit a felony;
 - (d) Participation in a riot or insurrection;
 - (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
 - (f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;

- (2) Is caused by or results from:
 - (a) Declared or undeclared war or act of war;
 - (b) An Accident which occurs while the Covered person is on active duty service in any armed forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
 - (c) Aviation, except as specifically provided in this Policy;
 - (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment

bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

- (e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and;
 - (i) The loss was caused by fire, heat, explosion or other physical trauma which was the result of the release of nuclear energy; and
 - (ii) The Covered Person was within a 25 mile radius of the site of the release either:
 - (1) At the time of the release; or
 - (2) Within 24 hours of the start of the release.

CLAIMS PROVISIONS

Written notice of claim must be given within 30 days after a covered loss occurs or as soon as reasonably possible. We will send forms to authorized members who ask for them.

Notice must be sent to the address below or call 1-800-591-6764

SDS, LLC
4676 HIGHWAY 41 NORTH
SPRINGFIELD, TN. 37172

Underwritten by: SERVE AMERICA, LTD.