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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas

The Honorable Eugene C. Griffith, Jr.

Case No. 2011-CP-32-04981
Appellate Case No. 2014-000671

Mike Russell, ... Respondent,

v.

Randolph Gill and Pennsylvania Life Insurance Company ..... Defendants,

Of Whom Pennsylvania Life Insurance Company is ..... Appellant.

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opposed to being driven. It had slid that couple feet up to where it was located when we got there.

Q Did it look like Ms. Collins or anybody else had moved the vehicle from the place of impact?

A No, ma'am. Because the mark from where it started, it stopped under the tire and there was no marking on the tire. And there was no separation between the end of the mark and the tire. If the car had been driven forward, then it would not have allowed the tire to slide to create that mark.

Q So what created the mark?

A A slide on where the vehicle had been struck while the tires were not in motion that caused the vehicle to move without the tires being in motion.

Q So the evidence that you saw at the scene indicated that the vehicle was stopped; the motorcycle hit it; and that caused it to slide?

A Yes, ma'am.

Q And where did it appear that the car was at the time that the accident happened?

A It appeared that the car had been attempting or had been stopped with 99 percent of it approximately out of the roadway in that area between the interstate ramp and the interstate. But the right rear of the car had been left in the roadway.

Q Was there anything about the exit ramp where the accident happened that was unusual?

A No, ma'am. That actually -- that part of the interstate ramp was actually fairly straight. Just beyond that the ramp makes a hard right and then goes down and makes a hard left to get you back to 321. But that's a -- a straight area of the ramp.

Q Could another vehicle have passed the stopped car, based on where it was parked at the time of the accident?

A Yes, ma'am. There was plenty of width to how that happened. As a matter of fact, even with the motorcycle there and our car parked behind it blocking the road post impact, traffic was still maneuvering to the right of our car and able to proceed around us to get off on the ramp.

Q Is that ramp a common place for accidents?

A Only during peak hours in that part of it. The -- the curved portions, it's not uncommon to have a wreck there, especially in bad weather conditions. But on the straight portion of the ramp, the majority of the collisions I've investigated there has been during peak rush hours or morning and the evening, when there's heavy traffic congestion.

Q When did you leave the accident scene?

A Once the towing services had arrived at the scene and got the roadway clear and the debris cleaned up, we left

and went on to Lexington Hospital.

Q Was there anybody else still at the accident scene when you left?

A At that point, no, ma'am. Everybody would've cleared the scene.

Q So you went to the ER after you left the accident scene?

A Yes, ma'am.

Q What did you do at the ER?

A I accompanied Trooper Harmon down to the hospital to the emergency room. We located Mr. Russell's room. We interviewed him about what had occurred. And at that time when I walked in the room, you -- you could smell alcohol. You talk to him; ask them what they been drinking.

And after talking to him and interviewing him, Trooper Harmon -- well, I was at the conclusion -- I -- I don't want to testify to what Trooper Harmon's conclusion was. But I come to the conclusion it was my belief that Mr. Russell was under the influence of alcohol.

Q He was able to talk to you?

A Briefly. Yes, ma'am. I remember briefly. I don't remember the complete context of the conversation. But he -- he was able for us to be able to talk to him. Once the conclusion was reached that it was our belief that he was under the influence, I made sure that Trooper Harmon

completed the necessary paperwork; requested the blood sample; and then he was charged with driving under the influence. I don't believe in this particular case that we ever transported him to jail when he was released, predominantly because the purpose of putting somebody in jail is to keep them off the road till they sober up. His medical situation was kind of going to take care of that. So he was not transported to jail.

Q Did Mr. Russell have any field-sobriety tests?

A No, ma'am. Given his -- his condition and the need for treatment and the fact that he'd been on a motorcycle, he'd gotten in a wreck, obviously, from the wreck he had came off of the bike. That's 99 percent of the time in a motorcycle wreck. It -- it was not possible to perform a field-sobriety test.

Q Did you request a blood sample?

A Yes, ma'am.

Q Did you arrest Mr. Russell?

A He was charged in the -- in the nature that the issuance of a traffic ticket serves as an arrest. He was, but to be taken into custody and booked into the jail, no, ma'am.

Q Did -- what tickets did you issue?

A It was a ticket for driving under the influence.

Q Was there another ticket as well: for operating a

motorcycle with an expired license?

A Very well may have been. Yes, ma'am.

Q We'll talk about that in a moment.

Did you see the blood sample get taken?

A Yes, ma'am.

Q What happened to the blood sample after it was drawn?

A The sample would be taken back to our office. It would be entered into evidence, placed in a refrigerator, and then taken on to -- at the time -- at the time I'm not sure which procedure we followed, if the officer took it to the hospital or not. But it would've been handled in accordance with the procedure that was in place and transport it to the State Law Enforcement Division for analysis.

Q I'm going to show you a document in what's been marked as Defendant's Exhibit No. 23. What is this document?

A This is the copy of the urine-blood-collection report. I can tell by the sloppiness of the handwriting that I prepared the heading on the document. It basically has the defendant's name information on it. It's dated at the time of arrest, where the blood sample was drawn, and the time. And -- and this blocked is checked that he's been placed under arrest for DUI; he's been advised of his implied-consent warnings; and that the blood sample was requested by the officer because licensed medical personnel has

determined that the subject's unable to be transported to jail for a breath test.

Then, it has a signature from someone at the hospital with a checkmark in the block indicating that a nonethanol prep was used to collect the sample. And then, the final checks indicates that it was collected under the officer's supervision; that it was -- excuse me -- it's in a properly labeled container with the subject's name and the time of the collection and that it is properly sealed for transported to be turned in to evidence. Then, that's signed by Trooper Harmon.

And then, there's a place where the person that's given the sample is allowed the opportunity to sign, indicating that he'd received a copy of the report. This indicates in my handwriting that he was unable to sign that report, and the reason for that being, the majority of the time when you talk to somebody in the hospital, they're still on their back. A lot of times they're still in the C-collar and backboard, and an ink pen just doesn't write real well upside down. So we'll put "unable to sign" there, as opposed to "refused," and still provide them a copy.

Q Describe a little bit more the protocol for dealing with blood evidence to be submitted to SLED for screening.

A There was one of two procedures that would've been in

place at this time, to my recollection. The first would've been for the officer to collect a sample, and then the sample would be turned over and transported -- turned in to evidence at our office. By that we have a chain of custody that we complete. The chain of custody then the -- goes into a refrigerator in the office, which is a locked refrigerator.

And then, the evidence custodian at the time, I believe, would've transported it to SLED. Under our current procedure, he take it to the central evidence facility; signs it over to them. They put it in a sealed refrigerator. Then they transport it all to SLED. I'm not sure which of the two we were doing at the time.

Q But you would've followed the standard procedure in place ---

A Yes, ma'am.

Q --- at the time?

A Yes, ma'am.

Q Look at the previous page that's number No. 418. Whose signature is at the bottom of this page?

A That's Sgt. C.M. Shelton, which indicates to me the first procedure that I described, where the supervisor took it straight to SLED instead of central evidence, was the person that delivered it there. Sgt. Shelton is actually my sergeant. And he is the evidence custodian in Lexington

County.

Q So this document shows that the Lexington County evidence custodian delivered the sample directly to SLED?

A Yes, ma'am.

Q Okay. What time was Russell's blood drawn?

A It's indicated that it was drawn at 0005 hours, which would be five minutes into the following morning after the collision.

Q Have you seen this report before -- this SLED report before, that you're holding in your hand?

A I may have seen it several years ago when it first come out. I'm familiar with the document. It's -- it's a standard document.

Q What -- look at the first page. What did the results of this SLED report show?

A Indicates that at the time that the sample was drawn, Mr. Russell had a blood-alcohol percent of 0.199 percent.

Q Let's look again at the traffic-collision report that's been marked as Defendant's Exhibit No. 5 and talk a little bit about some of the details that are shown on this report. Will you read the description of what happened that's on the front page of this report at the bottom corner.

A States that: "Units No. 1 and No. 2 were eastbound on I-26 exit ramp to US 321. Unit No. 2 stopped on the side

with the rear corner still in the roadway. Unit No. 1, driving under the influence, struck Unit No. 2 in the right rear.

Q What was the weather like that night?

A It was clear that night with no adverse conditions.

Q And that's indicated on the second page of this report in the block called "Weather Condition"?

A Yes, ma'am.

Q In the description of the sequence of events that's in the middle of this page, what's the report indicate?

A Event No. 1 for Unit 1, which is listed as Mr. Russell's vehicle, it indicates that the first harmful event to him -- it -- it's actually listed improperly. It should say "motor vehicle stopped." They've changed the way that we've done these over time. This was proper at the time to indicate what the vehicle was doing. Now they want us -- what the vehicle struck was doing.

Q Oh.

A So it's 180 degrees from what we do today. But it's actually indicating it improperly from the standard they have today. We've transitioned from paper reports to computer-generated reports. The Office of Highway Safety and the DMV has got a lot more involved in how they want them done. So a lot of that has changed from the way that we were doing them before.

Q So based on the time at which this report was created, it shows that Unit No. 1 was in transit and Unit No. 2 was stopped?

A Yes, ma'am.

Q In the section that's called "Manner of Collision," it says that there was -- that it was an angle with an arrow pointing up and to the left. Can you explain that to us?

A The collision was an angular impact. It wasn't a straight, front-to-rear impact, because the car was stopped at an angle and the impact came and struck the left rear of the car and then went down the side of it from the way that it was turned. And it's shown as an angular collision, as opposed to a straight, rear-end collision.

Q How do you know that's how the impact happened?

A From looking at the debris in the roadway; from speaking with the drivers; finding evidence that's consistent with her story. Ms. Collins' statement was fairly consistent with what had occurred, with the exception of the discrepancy of whether or not the vehicle was completely out the roadway.

Q When you say "completely out of the roadway," you mean whether or not the right-rear corner of her car was over the white line by how much?

A Not more than two feet. Again, that was the only discrepancy. Our interview with her revealed that she

thought the vehicle was out of the roadway; the physical evidence contradicted that. And anytime you have that, you have to go with the physical evidence.

Q Was that discrepancy in her description and your evaluation of the evidence something that gave you concern at the time you were investigating?

A Not particularly. It's a matter of perception. It's kind of like of pulling into a parking place and you think you're all the way in it and then you get out and you looked and you're a little bit over the line on the right side. Sometimes we just misjudge the -- the width and length of our car when we're trying to put it somewhere.

Q What was the road-surface condition like that night?

A It was dry.

Q And the weather conditions were clear?

A Yes, ma'am.

Q Was it dark?

A Yes, ma'am.

Q Was it unsafe?

A No, ma'am. I mean, the -- to my recollection, we didn't have a particularly high volume of calls that night. It was an ordinary night in Lexington County: a clear night, a dry night. There was no excessive traffic volume out at 9:20 -- 9:25 at night. There was nothing about that night to distinguish it from any other.

Q What is the contributing-factors section on the bottom of the second page of this report say at ---

A It indicates that the primary contributing factor to this collision was driving under the influence. Again, with the change in the way we do thing, it should also show a secondary for the parked in the roadway. But the primary contributing factor, in our opinion, was the driving under the influence.

Q Were there -- was there any other evidence or any other parts of your professional experience that indicated, based on the evidence you saw at the scene, that this accident was caused by driving under the influence?

A Yes, ma'am. In the course of DUI detection and in the course of my training, DUI on a motorcycle to detect is a little bit different than DUI in a car. With a car you typically look for people that are driving left of center and weaving. The things that I see on motorcycles is they tend to follow straight beside either the right-side fog line or the dotted line.

Q What's the fog line?

A The fog line is the solid line on the right-hand shoulder -- the far-right shoulder of the roadway. It's the white line that helps people stay oriented so they don't run off the right shoulder of the roadway.

Q Okay. Sorry to interrupt you. So they drive along

that fog line?

A Well, they'll either do that, or else they'll follow the dotted line that serves as a lane divider. Or occasionally, if you're stopped behind them, you'll notice when they start off from a stop. They can't pick their feet up and go; they got to get a running start and get it rolling so they can keep their balance to proceed.

In this case, from looking at the point where the collision occurred, it was just right over the right side of the line. There was plenty of room further to the right where a vehicle could've went around Ms. Collins' car. And if a vehicle can make it, surely a motorcycle could.

But he continued straight, right up on the fog line, and struck the car. There was no evidence of preimpact braking on -- on the motorcycle. And that was one of the things. And then, looking at it -- especially after talking to him at the hospital, realizing that, in our opinion, he was under the influence -- that kind of reinforced our opinion that he was under the influence.

Q When would Mr. Russell have gotten this document?

A The accident report?

Q Yes, sir.

A As a matter of course, we don't provide people with copies of the collision reports. What we provide them with is an FR-10. The FR-10 has limited information on it. It

mainly deals with the people involved's names; addresses; drivers' license numbers; the registration numbers of the vehicles. And it also lists on there the insurance information for the auto insurance.

And we provide each party with a copy of that. They're required to take it to their insurance company. The insurance company will fill it out. And it has to be returned to the Department of Public Safety within 15 days of the date of the collision. From there the insurance companies will general purchase a copy of the report through ---

Q The auto insurance ---

A --- DMV ---

Q --- company?

A Yes, ma'am, the auto insurance company. They will get a copy of that through the DMV. And people ask me all the time at the scene if they can get a copy. I always tell them: For what you pay your insurance company, surely they can make you a copy of the report; they're going to buy it anyway.

And it generally takes anywhere from four to eight weeks for it to be available for purchase. It just depends on how quickly they get them loaded in the computers at DMV.

Q That document that I just handed you has been marked

as Defendant's Exhibit No. 6. Is that the document you were just describing, the DMV notice of requirement, FR-10?

A Yes, ma'am.

Q A few minutes ago, you talked about issuing tickets to Mr. Russell. I'm going to hand you a document that's been marked as Defendant's Exhibit No. 7. What's this document?

A It's a copy of two uniform traffic tickets that were issued by Trooper Harmon. The first is for driving under the influence of alcohol. That's D365378. And also, D365377 for having an expired motorcycle license -- I'm sorry. Yes. That one looks like a -- it was an expired motorcycle license.

Q Would you have reviewed these tickets before Trooper Harmon issued them?

A I wouldn't have specifically necessarily reviewed them. But I would've made sure that he was making the proper charges in both regards.

Q Is it normal highway patrol procedure to issue uniform traffic tickets in these situations?

A Yes, ma'am. Even if we have made a custodial arrest, he -- he would've been issued a traffic ticket for those offenses.

Q When -- when would Mr. Russell have got these tickets?

A He would've received the copy of the tickets that night. Even if we had decided to take him into custody at

the time they were completed, he would've been given his copy. Just in case there was some confusion and he left the hospital before we were able to pick him up, he would've already been served with the tickets and we could still proceed with a normal trial date.

Q Why did you issue a ticket for driving under the influence to Mr. Russell?

A It was our opinion at the time -- and it's my opinion today, based upon the evidence -- that Mr. Russell was under the influence of alcohol at the time of the collision.

Q Thank you. That's all the questions I have for you right now. I'll take all these things from you.

CROSS-EXAMINATION

BY MR. MOORE:

Q Hello, Mr. Rothell.

A Good afternoon.

Q How are you?

A Wonderful.

Q I'm glad to hear it. So happy to be here. Now, I want to make sure I understand something. Mr. Harmon was the primary investigating officer on the official records of the State of South Carolina, correct?

A Yes, sir. I was his supervisor. I was at the scene, charged with training him.

Q Right. And you've already testified that you and he investigated it, correct?

A Yes, sir.

Q And y'all both came to the same conclusions?

A Yes, sir.

Q Now, I thought we had an Exhibit No. 6 somewhere around here.

(Whereupon, Mr. Moore and Mr. Riley conferred.)

Q I'm going to hand you -- the lawyers are doing too good a job for me -- Exhibit No. 9. I think you were asked that this was Exhibit No. 6. I don't know.

MR. MOORE: Madam court reporter, could you mark this for me? I just want to make sure it's in the record.

(Whereupon, Mr. Moore and Mr. Riley conferred.)

THE COURT: Six was a defense exhibit.

MR. MOORE: Could I see that, Your Honor?

THE COURT: Sure.

MR. MOORE: Yep. Exhibit No. 6 works for me.

Q Exhibit No. 6 is what's called the "FR-10 form," correct?

A Yes, sir.

Q And this is an official record of the State of South Carolina, correct?

A Yes, sir.

Q And on this record is the official indications of what

the State of South Carolina is, in effect, reporting to the various insurance carriers. That's the way it works, right? That's what FR-10 does.

A To some degree. Yes, sir. But the -- the collision report is going to contain all of the information.

Q Sure.

A The FR-10 ---

Q Because ---

A --- is basically there for insurance-verification purposes.

Q Right. It's there for an insurance verification and reporting purposes, right?

A Correct.

Q All right. So what is here is the -- there is information here that is officially being filed as the official position of the official investigating officer of the State of South Carolina?

A No, sir. That's actually not filed at all with the State of South Carolina, other than for insurance verification. The collision report is the record of what happened.

Q Well ---

A That is an insurance-verification form.

Q This would appear to have been delivered by the State of South Carolina by virtue of a subpoena. Do you know how

the State of South Carolina would've gotten it if -- had in its possession pursuant to a subpoena?

A Well, because when the -- when it was filled out by the insurance company, it would be returned to the Department of Motor Vehicles at that point for verification.

Q I see. So what happens is the insurance company gets it; and then they give it to the -- the highway department or motor vehicles and they keep it, right?

A Yes, sir. And it -- and it's for the purpose of insurance verification.

Q And we can look at this form and tell lots of things: who was in the wreck, and the opinion of the investigating officer in regard to who contributed to the accident, and all that sort of stuff, right?

A Not necessarily. I -- I see there that it's on there.

Q Well, let's talk -- all right. Let -- let's talk ---

A It -- it's ---

Q --- about ---

A --- been corrected on the official collision report.

Q And we'll talk about that too. Let's take a look at -- who -- when it comes to my client, on the FR-10 form that you say you agreed with the man's opinion that night, does it show my client as having contributed to the accident?

A No, sir. And it does not reflect the opinion that night. That's an error that was corrected before the report was submitted.

Q Well, let's talk about that error. What it says is: Mike Russell -- it basically has a box that says "contributed to collision"; answer "no"; right?

A Right. That is incorrect.

Q Well ---

A It was corrected on the TR-310.

Q Well, it's not incorrect that that's what it says on the form?

A Yes, sir. It was incorrectly put on the form. That ---

Q And that ---

A --- should've never been put there.

Q And that form is basically a form that you didn't fill out; that was filled out by Mr. Harmon?

A Correct. And it was improperly done.

Q All right. So we know that at least in regard to the writing on the FR-10 form, the person who did contribute to the accident was Connie Lynn Collins, right?

A By the FR-10, that was improperly circled; it was contrary to the opinions that were formed that night. And it was corrected on the TR-310.

Q I just want to go by the official FR-10 form.

According to the FR-10 form that was given that night at the scene by the investigating officer, Mr. Russell did not contribute to the accident, according to the form, right?

A Right. It was improperly filled out. And according to the form, it shows him as not contributing.

Q Very good. Now, let's take a look at the actual accident report itself. I think this is more of Exhibit No. 9. If we look closely at it, we can actually see on the form where, on Ms. Collins contributed to accident, it says "yes," correct?

A Right. And again, that's an error that was corrected when I reviewed the report.

Q Show me where it was ever corrected. This appears to be the official report.

A It shows both parties contributing. You can see where "no" was initially circled for Mr. Russell. Now, the reason for that being is the way that these reports at the time were done -- now are computerized -- is what you have as Exhibit 9, the front page is the front; the back is the back. The FR-10s are carbonized forms. There's three of them that go under it. So when he circled it here, it went all the way through. It was corrected here on this report when I checked it; however, the FR-10 had already been issued.

Q Let's ---

A That's the reason the correction shows up on this report. It's not two forms we fill out separately. It's all generated when you put pen to paper, for one thing.

Q Well, the accident -- actual accident report that I'm holding in my hand, this has been corrected to be accurate, correct?

A Yes, sir.

Q All right. Well, this still shows Ms. Collins as contributing to the accident, does it?

A Correct. Both parties were show as contributing to the collision: Mr. Russell for driving under the influence, and Ms. Collins for stopping with the rear of her vehicle in th roadway when it was practical to stop for a vehicle without blocking the roadway.

Q And if we look at the actual block for Mr. Russell, you can see where "yes" and "no" are circled on the actual form that is Exhibit No. 9?

A On the TR-310 you can see where "no" had been circled in error and was corrected with white-out and "yes" was circled.

Q Well, actually, it doesn't appear to be corrected with white-out; it just appears to have been a -- well, you can still see where it's circled on there, can't you?

A You can ---

Q You can ---

A --- see the ---

Q --- make it out.

A --- remnants of it. But yes, sir. It was corrected with white-out. I can tell where the line was blotched out. If I compare the FR-10 to the TR-310, you can see the FR-10's almost complete solid line around, and the TR-310 isn't. The TR-310, the -- when it was circled "no," it formed the indention on the FR-10 to make it a "no." So with a line being less solid on the TR-310 and the FR-10, it does indicate that that was a correction that was made. The standard practice with a paper report on making corrections is to use white-out.

Q Now, let's make sure, then, we talk about the conduct of Ms. Collins in regard to what caused the accident. As I understand it here, we're talking about an exit ramp off of an interstate, correct?

A Yes, sir.

Q One is not supposed to stop on an exit ramp coming off the interstate, is he?

A We're -- you're not supposed to stop on a controlled-access highway at all unless you're required to do so because of traffic conditions or if you're required to do so because of a mechanical failure. Even in the event of a mechanical failure on any roadway, you cannot stop in the roadway unless it is impractical to be able to get your

vehicle out of the road.

Q And she did not have a mechanical failure, did she?

A No, sir. I ---

Q And so she was stopped in a controlled-access highway, correct?

A Yes, sir.

Q She was stopped where she wasn't supposed to be stopped, correct?

A Yes, sir.

Q And other vehicles on the roadway had a right to assume that she would obey the law, correct?

A Yes, sir. They also had an obligation, though, not to strike her if they had a reasonable distance to do so.

Q Sure. I understand. I'm just trying to talk about her. All right?

A (Nodded head up and down.)

Q So we do know that she was parked where she wasn't supposed to be parked in a controlled-access roadway, correct?

A Yes, sir.

Q And we know the collision was hard enough to have actually moved her vehicle once she was struck, correct?

A Yes, sir.

Q We know that she was stopped on the controlled-access highway with no legitimate reason you could find, correct?

A I believe she had actually dropped her cell phone and was trying to pick it up.

Q Right. So what she told you had happened is she had been talking on her cell phone?

A No, sir. She told me that she had dropped her phone and that she had pulled over and that she had stopped out of the roadway and he struck her. The physical evidence I don't not match her vehicle being completely out of the roadway. She misjudged the distance by 1 to 2 feet, still plenty of room for traffic to move around, but at the same time, improper to be stopped in that lane of traffic. The physical evidence did not support her statement 100 percent. We went with the physical evidence, and she was charged for parking her vehicle or stopping her vehicle on that portion of the roadway.

Q Because even if she dropped her cell phone like she said, she should not have stopped with a portion of her vehicle in my client's lane of travel, should she?

A Correct.

Q All right. And there were portions of her story that did not match up to the physical evidence, correct?

A Yes, sir. The -- the misjudgment of the distance did not match.

Q And for a person to stop on a controlled-access highway with a portion of the vehicle in the lane of travel

is dangerous, is it not?

A Yes, sir.

Q When you got there, did you find any evidence that her lights were on?

A I don't recall.

Q And when you got there, what time of day did you determine the accident happened?

A Approximately 9:24 p.m.

Q So at 9:24 p.m. even in June, it's dark, right?

A Yes, sir.

Q So as I understand it, she's illegally parked ---

A Well ---

Q --- on a ---

A --- she's ---

Q --- controlled ---

A --- she's stopped more than parked. I don't know if the vehicle was in park or foot on the brake. But she was not in motion on the interstate, which was improper unless she had a legitimate reason, such as being broke down or other traffic.

Q Well, you charged her with illegal parking.

A I think the law is unlawful stopping, standing, or parking on a controlled-access highway. I think it covers all of them. I'm not particularly sure which statute it was under.

Q She was unlawfully stopped where she was, correct?
A Correct.
Q With a portion of her vehicle sticking to a travel portion of a controlled-access highway, correct?
A Correct.
Q In the dark?
A Yes, sir.
Q With about 2 -- 1 to 2 feet of her vehicle sticking out, correct?
A Yes, sir.
Q And without, as far as you know, no emergency flashers on, correct?
A To my knowledge. I -- I don't know.
Q All right. So one thing is for certain: There can be no question but that the driving of Ms. Collins was a significant contributing factor to what took place, correct?
A It was a contributing factor. I -- in my opinion, Mr. Russell was the primary contributing factor.
Q Well, if she hadn't done what she did illegally, this would not have happened because the car wouldn't have been there, right?
A Understand. But my opinion, had he been sober -- given the fact that even if the lights were off, the tail lights were reflective; the tag is reflective -- his

headlight would have shined onto her car. He's on a highly maneuverable vehicle, being a motorcycle. Had he been sober, he should have been able to avoid the collision.

Q So he's primarily at fault because he doesn't drive around her screw-up?

A Well, the way that you put it, I don't agree with totally.

Q It was ---

A In my ---

Q --- her screw-up ---

A --- opinion ---

Q --- wasn't it?

A In my opinion, it was more her -- his than hers, because there's no reason he couldn't have avoided that hazard.

Q Well, there's no -- do you have any indication that he was doing anything illegal before -- except being under the influence, but as far as the way he was operating that motorcycle, you got any indication that he was operating that motorcycle improperly before he struck her?

A Mr. Moore, to be honest with you, with the blood-alcohol level he had, that's improper enough to establish that.

Q I sit beside that. But, of course, as we both know, in order to be guilty of driving under the influence of

alcohol, the alcohol has to influence your driving, correct?

A And I believe it did by preventing him from avoiding that hazard that was a foot into the roadway ---

Q The hazard ---

A --- when you had 8 to 12 feet to get around it.

Q Well, do you have any evidence that he was speeding?

A No, sir.

Q Weaving?

A No, sir.

Q Basically, not looking at the road?

A Well, and again, alcohol is an impairing factor that prevented him from seeing the road.

Q Yes, sir.

A And in any regard, he was driving with an unlawful alcohol concentration under 2933.

Q Well, and, of course -- well, okay. But that's -- that's BAC. That's not driving under the influence, right?

A Right. It's basically the same thing. But with the way the law is written, even to proceed with the DUAC at trial, we would've had to made the DUI charge originally

Q That's right.

A --- and amend it later.

Q So the situation we have here is the chain of events that led to whatever happened here was when Ms. Collins

created the obstruction in the roadway. That's true, isn't it?

A In part, that's true. But in part, it also deals with the fact that he was too intoxicated to avoid the obstruction on a clear sight distance.

Q Well, let's talk about how intoxicated he was. When you got there, he was laying in the roadway, wasn't he?

A I believe he was already gone to the hospital.

Q He's already gone to the hospital. No -- you -- so you did no field-sobriety tests, correct?

A Correct.

Q You never saw him driving, correct?

A Correct.

Q You know of anyone that did -- you don't know of anyone that did see him driving?

A Ms. Collins would've saw the tail end of it or at least felt it.

Q Ms. Collins was there; she got hit. But that's all she knows ---

A Correct.

Q --- right?

All right. Nobody can say that he was staggering drunk?

A He was laying in the road. I mean, to be honest, he just wrecked a motorcycle. He -- even if he gets up and

he's staggering, he's hurt.

Q Sure.

A I can't give a man a one-leg stand when he just wrecked a motorcycle.

Q Well, my question is: Do you have any firsthand knowledge, other than the fact that an accident happened and he had a high blood reading, that he was intoxicated?

A The combination of the blood-alcohol reading, the manner in which the collision occurred, the opportunity he had to avoid it, all, in my training and experience, led me to believe that he was under the influence of alcohol.

Q And there was no DataMaster given, correct?

A No, sir. A blood sample was drawn because he was physically unable to go to the hospital to render a DataMaster.

Q Right.

A So to be honest with you, Mr. Moore, my opinion that he was under the influence was not based upon a blood-alcohol reading that I didn't have at the time. It was based off of what I saw and observed at the scene and then reinforced by that reading when it come back from SLED.

Q Well, who made the mistake from the highway patrol's posture when they circled that my client wasn't at fault? Is that your error, or was that the investigating officer's error?

A Trooper Harmon made the initial error in completing the form. And I made an error by not seeing it that night. However, upon approval of the actual report, it was caught and corrected.

Q So you are capable of making errors?

A Yes, sir.

Q You are capable of being wrong?

A I'm human.

Q But there's no doubt in your mind that Ms. Collins was in the roadway creating a dangerous condition and contributed to this accident, correct?

A She created a condition that contributed to this collision. Yes, sir. But she did not create an unavoidable situation.

Q Did you ever ask her, "Hey, Ms. Collins, look, you're on a controlled-access highway. You're on an exit ramp, coming off of the interstate at night. Couldn't you have waited until you got to a parking lot to pick up your cell phone?"

A Yes, sir. I -- I do not recall specifically stating that. But I can tell you, as a matter of course, I routinely ask people that: Why didn't you stop? Why didn't you wait? Just like the guy speeding 90 because he's got to pee, I'm going to point out to him there was a exit a mile back.

Q And she did plead guilty to the improper stopping, correct?

A I don't believe so.

Q What happened to that?

A If I recall correctly, that one might've been dismissed at trial. I can't recall.

Q You just don't remember?

A Yeah. I -- I want to say Mr. Russell may not have appeared in that case. I -- I can't recall.

Q Okay. Very fine. Of course, it'd be good reason why he couldn't appear if he's in the hospital, wouldn't there?

A Well, I think both of them wound up initially being jury-trial requests and went some point down the road. At that point -- at the point when both of these came to trial, Trooper Harmon was no longer under my direct supervision. And I -- I'm really, you know ---

Q So the DUI and the improper stopping got dismissed?

A I -- I believe off a lack of witnesses where the officer made a mistake in preparing for prosecution of the trial. It was not dismissed as a result of lack of evidence, but more as the lack of doing what you needed to do to be able to present your evidence.

Q So from a -- from the traffic standpoint, neither of them were found to have contributed to the accident?

A Yes, sir, they were. They may not have been convicted

of the crimes of which they were charged, but they were shown as contributing criminally.

Q Neither of them were convicted of any charge?

A Correct. And it was because of procedural errors in the preparation of the trial, not the result of a judge or a jury verdict based on the facts.

Q And -- and -- but that's basically, as a matter of law, both of them were basically found not guilty?

A Correct.

Q All right. Thank you so much, trooper.

THE COURT: Anything else, Ms. Horne?

MS. HORNE: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. HORNE:

Q Do you know whether or not Ms. Collins' charge actually went to a jury?

A If I recall correctly, it was dismissed based upon the fact that Mr. Russell had failed to appear at trial. I don't know if he was notified or what. That was -- at that point Trooper Harmon was no longer my trainee. He was his own trooper. And whether or not Mr. Russell was advised to be there or not, I don't know. But on the date of trial, he was not there. And without him there, we could really present no evidence that wouldn't have been hearsay.

Q Is it possible that she had a jury trial and was found

not guilty by the jury?

A It's possible, but I don't believe so.

Q Okay. If a phone or some other object is underneath a gas pedal or a brake pedal of an operating vehicle on a roadway, is that a -- a reason to stop their car for mechanical difficulty?

A If -- if it impaired your ability to operate the vehicle safely, then they would have to take some action to be able to continue on safely.

Q Safely? No further questions.

MR. MOORE: Thank you. Nothing further.

THE COURT: Corporal, thank you so much for coming.

THE WITNESS: Thank you, Your Honor.

THE COURT: Sorry you had to come all the way to Laurens.

THE WITNESS: No problem. It's a lovely drive, Judge.

(Whereupon, the witness exited the witness stand.)

MR. KRISTINIK: Your Honor, can I ---

THE COURT: And -- and can I clarify for the record that Exhibit 9 is Plaintiff's Exhibit 9, which is the accident report; and then, Defendant's Exhibit 5 is also the same accident report? Because I've been looking at Exhibit 5 as the TR-310. Exhibit ---

MR. MOORE: This is FR-10.

THE COURT: FR-10 is Exhibit ---

MR. MOORE: Well, I can ---

MR. RILEY: And it's -- Your Honor, in the plaintiff's exhibit, it's Exhibit 9 and the FR-10 is with Exhibit 9 on the plaintiff's side. The defendant's do not match the plaintiff's exhibits.

THE COURT: Right. I understand that. But Ms. Horne was utilizing Exhibit 4?

MS. HORNE: Six.

THE COURT: Six is -- is the FR-10, and 5 is the accident report as she was asking questions of this witness. On cross-examination it went to Defendant's Exhibit 10?

MS. HORNE: Yes, sir. Thank you for ---

THE COURT: Just so we keep straight.

MS. HORNE: --- wading through all that.

THE COURT: Okay.

MR. KRISTINIK: Your Honor, we would request a brief break ---

THE COURT: Sure. Glad to.

MR. KRISTINIK: --- before we present our last witness. Oh. Your Honor, may Trooper Rothell be excused?

MR. MOORE: Oh, sure.

THE COURT: I'm not excusing him. Y'all brought him up here. Yeah. He can go.

(Off the record from 2:32 p.m. until 2:41 p.m.)

THE COURT: Ready?

MS. HORNE: Yes, Your Honor.

THE COURT: All right. Call your next witness.

MS. HORNE: All right. We'd like to call Lt. Wendy Bell to the stand, please.

THE COURT: Is it Bell?

MS. HORNE: Bell.

THE COURT: All right. Ms. Bell, come forward and be sworn.

(Whereupon, the witness came forward.)

WENDY BELL, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HORNE:

Q Will you state your full name and spell it for the record, please?

A It's Wendy Bell, B-e-l-l.

Q Where are you employed?

A I'm employed with the South Carolina Law Enforcement Division in the toxicology department.

Q How long have you worked for SLED?

A I'm -- since 1998, so this February it'll be 15 years.

Q What's your specific job at SLED?

A I'm the chief toxicologist, which means I supervise the 14 individuals in that staff.

Q What is a forensic toxicologist?

A We study biological fluids for the presence or absence of alcohol or drugs or other poisons. And we are able to test for those in biological fluids, including blood, urine, brain, liver -- whatever tissues that are submitted. And we also are trained to be able to interpret what those findings mean once our analysis is complete.

Q What are your duties?

A Well, currently, as a supervisor, I'm in charge for all of the work that goes out of the laboratory. I hire; I write the protocols. I help develop the policies and procedures for the department.

I still do some bench work. I -- I was on the bench as an analytical toxicologist for nine years and have been a -- supervisory position since then. So I oversee the training of our new staff, purchasing of equipment, anything that would be needed in the department.

Q What's your educational background?

A I have a B.S. in chemistry from Furman University and a Ph.D. in analytical chemistry from the University of South Carolina. When I started SLED in '98, I began my training as a toxicologist under the direction of Dr. David Eagerton, who is a Ph.D. pharmacologist now at the pharmacology school here in Presbyterian College, right down the road. So he directed our training. In toxicology

it's an ongoing process; every year we continue to add -- I've -- I've graduated from the Borkenstein School of Drugs and Driving, as well as the Borkenstein School of Alcohol and Driving, where the premier scientists from around the world in alcohol analysis and in drug testing come and teach that to toxicologists from around the country.

Q What's that course like?

A It's a -- it's an in-depth course. I mean, that was actually just a few years ago. Really helps -- it -- it's a good opportunity to get to meet the leading researchers in the world on the subjects.

Q Is there any other specialized training that you've received in toxicology?

A It's just been ongoing. It -- it's a career so ---

MS. HORNE: At this time I would present Lt. Wendy Bell as an expert in the field of forensic toxicology and analytical chemistry.

MR. MOORE: Sure.

THE COURT: So stipulated and so qualified.

Q I'm going to hand you a document that's been marked as Defendant's Exhibit 23. What are these documents?

A This appears to be a copy of the SLED toxicology case file.

Q Let's talk about the chain of custody first. What's the procedure by which a specimen is received in the SLED

lab for analysis?

A Well, in -- all evidence comes into the SLED laboratory through our evidence-control department. So the officers themselves or someone from their agency bring that evidence to evidence control.

THE COURT: Can we ---

A And they actually submit the evidence ---

THE COURT: Can we ---

A --- themselves.

THE COURT: --- stipulate to the chain?

MR. MOORE: Yes, sir. I ---

THE COURT: Stipulate to the chain.

THE WITNESS: Okay.

Q Was a specimen submitted to the lab regarding Michael C. Russell in June or July of 2008?

A Yes. It was submitted to the laboratory on June 19th in 2008.

Q Was analysis performed on the specimen?

A Yes, it was.

Q What analysis was performed?

A This was a blood sample. And blood-alcohol or headspace gas chromatography, and headspace gas chromatography with mass spectrometer was performed, which looks for volatiles; quantifies it; and also confirms it in blood.

Q Is there a standard procedure for performing this analysis?

A Yes, there is.

Q Can you describe that for us?

A Okay. Well, at first, the evidence would be opened. We verify -- we have a heat-sealed pouch where the evidence is contained. So we make sure that there's no contamination; no one has been able to access the evidence, other than the officer who brought it in. The analyst would open that; remove the blood from -- the tube from the pouch.

They have a sequence that they're going by. And analytical standards are run every 15 samples. So every 15 samples in the run, we run a 0.08 standard to make sure that our instrument and our pipettes and all are working properly on that day.

This -- the individual sample would be run in duplicate. And we do that because it is an analytical measurement, and there's always a little bit of variability. We actually report the lower number of the two. And all of the quality-control checks from that day would have to be in.

It -- it's a very extensive process. I could go into more detail, but ---

Q I think that -- that explains enough for ---

A Okay.
Q --- the laypeople in here to understand what happens. Is this procedure or this particular analysis state of the art?
A It is the best way to do this analysis. But it has been around for some time. This has been in place since the '50s or '60. Okay. The -- we actually take it one step further and do a mass spectral analysis, which is one of the few states in the country that do that. So that part is state of the art.
Q And what additional value do you get by performing that special, additional test?
A That's simply showing that the peak that is analyzed is nothing but ethanol; there's no other contributors to the peak. It -- it's -- it's pure ethanol.
Q And the test is precise and reliable?
A It is.
Q And what does -- what does the analysis that you did on this sample for Mr. Russell measure?
A Our lab found a 0.199 percent ethanol in the blood.
Q Have you personally reviewed this analysis?
A I have.
Q How does a -- a person of Mr. Russell's height and weight achieve a blood-alcohol level of 0.199?
A I was given that Mr. Russell weighed approximately 185

pounds. Based on that, we can do several calculations that help us know what the minimum amount of alcohol that would have to be consumed to get to this type of level. That's using the Widmark equation, which has been around since the 1930s. It was discovered by Erik Widmark, who's a Swedish scientist.

Based on these calculations, Mr. Russell's weight, at an estimate of 185, it would take 5 fluid ounces of pure ethanol. Now, to break that down into what that means: That's equivalent to 12 ounces of a 40-proof liquor. It ---

Q Is Crown Royal a 40-proof liquor?

A I mean, 80-proof liquor, 40 percent liquor. Excuse me.

Q Okay.

A I misspoke on that.

Q Thank you.

A 80 proof, 40 percent. Yes. Crown Royal is a -- some forms of Crown Royal are 40 percent. Some -- there are some -- there's a Crown Royal Black that's actually 50 percent, which would be 100 proof.

Q And you said it would require consuming 12 ounces of an 80-proof liquor like Crown Royal to achieve a blood-alcohol level of 0.199?

A It would.

Q In what period of time would a person have to consume that?

A That's if it was all drunk at one time. That's the minimum amount it would take to get to that level. To maintain it over any period of time, it would take more than that.

Q I'm going to show you a document that's been marked as Defendant's Exhibit No. 3. This is a receipt from Carolina Wings and Rib House. During the course of these proceedings, we've discussed these items before, so I'll quickly read the items that are on the list on this receipt: Bud Light bottle, Crown Royal, Southern Comfort, Crown Royal, Jager, Jager, Crown Royal.

Is -- are the items that are listed on this receipt sufficient for a person of Mr. Russell's height and weight to have a blood-alcohol level of 0.199 at about midnight?

A It is possible. Around 2006 or 2007 -- I can't remember the exact year -- our state eliminated the mini-bottle law. Prior to that we could do a little bit better estimations of how much alcohol is actually consumed because that -- we know that they were getting a 1.5-ounce shot with each pour. Now that we have free pour, it's a little harder to determine exactly how much alcohol was consumed.

Q Okay.

A If all of this was consumed, it would actually take some pretty stiff shots of these liquor drinks to get to that level. It -- it's equivalent to about 8.3 drinks. And I see here seven.

Q So if the drinks that were poured that are listed on this receipt were all poured in excess of 1.5 ounces and they were all consumed in about an hour, that could be enough to get him to a blood-alcohol level of 0.199?

A It -- it would be. If ---

Q It would be?

A It -- if they were a little bit more than at 1.5 ounce.

Q But if they were at 1.5 ounce, then it would require more than what's listed on this receipt?

A Yes.

Q Okay. Based on the information that's available to you and your experience and knowledge, can you determine what Mr. Russell's blood-alcohol level would have been at roughly 9:30 in the evening, based on this information available at roughly midnight?

A Well ---

Q Are you able to generalize about that?

A A person eliminates approximately a 0.015 an hour. So -- and that's most -- that's an average over all individuals. An experienced drinker -- actually, their

liver can develop the potential to do more. They can actually eliminate up to a 0.02 an hour.

People -- so we -- we don't really like to do retrograde extrapolation. But we can estimate that, in our experience, it usually is higher ---

Q Okay.

A --- if you go back in time.

Q Is it possible to have had a blood-alcohol level of 0.199 if Mr. Russell had had only three drinks?

A No. Each -- each 1.5-ounce drink, an individual can get to about a 0.025 per drink. That would put him at about a 0.075 if they were all consumed in a very short time period, back to back.

Q Okay.

A If it was -- you cannot get to an 0.1 with only three 1-ounce drinks.

Q Is there any medical treatment or medication that can cause an elevated blood-alcohol level?

A Not other than infusing someone with ethanol. I mean, and that is -- that is a treatment. And the only reason I say that: If -- if you get methanol poisoning, they infuse you with ethanol to keep you from going blind. But that's the only way. There's no -- there's no medicine that causes it to inflate.

In fact, if you're given IV fluids, it actually pulls

ethanol back out of the water-storing cells in your body. And it -- it really doesn't create a huge change but, if anything, it dilutes it. Giving a blood infusion would lower it. So there are very few treatments, if any, that would cause it to increase.

Q Have you had the opportunity to review the medical records from Mr. Russell's admittance to the Lexington ER?

A I have.

Q Have you seen any treatment or other medication in his medical records that would cause him to have an elevated blood-alcohol level?

A I know sometime later he was given painkillers and things. Obviously, I'm sure he was in a great amount of pain following the accident. So he was given treatment for that. But none of those medicines cause ethanol to dump into the blood for any reason at excess level.

Q And the thing that you're measuring in the -- the test that you ran in your lab was ethanol specifically?

A That's correct.

Q Okay.

A Well, it looks -- it looks for other volatiles as well. There were none other present.

Q That's what I was about to ask you. If an alcohol-based swab had been used to draw Mr. Russell's blood, would you be able to distinguish that in this report that you ---

A They ---

Q --- prepared?

A --- don't use ethanol swabs. They use isopropanol. And that would show up as a different alcohol. And yes. We could determine if that was there. But it was not in this case.

Q Okay. Great. Let's look for a moment at these medical records. We'll start at page 114.

A Sure.

Q Do these -- have you had an opportunity to review these records before testifying today?

A I have.

Q Do the medical records indicate that Mr. Russell had an elevated blood-alcohol level in the ER after his wreck?

A Yes, they do.

Q Where in the records can you see that?

A Midway down the page, there is a test for ethanol. It looks like, on 6/18/2008 at 2248, the ethanol reading was a 0.232.

Q Are the hospital lab results that we're just looking at, are they consistent with the SLED results from your lab?

A They actually are. Hospitals usually perform ethanol tests in serum, whereas our numbers are a whole-blood number. Whole blood has the red cells still in the -- in

the system, so there's actually less of a liquid portion there. Serum has the red blood cells removed.

And so a -- a correction has to be done to be able to correlate a serum level to a whole-blood level. And the average for doing that is divide the -- to divide the number by 1.18. And again, that's an average; 1.18 to 1.2 is what's usually used. And if you do that, it comes out the numbers are almost identical.

Q So these are very consistent results?

A Yes, they are, which would mean that this -- this number is not actually a whole-blood number as it would relate to, like, a 0.08 being the legal limit. It -- it would be slightly lower than -- than that.

Q Okay. In your training what have you learned about the ways in which alcohol can affect an individual?

A Well, all individuals are affected by ethanol. Some have -- do develop tolerance. But -- but all individuals are impaired at -- at a -- particularly at this type of level. Some of the things that come into effect -- driving is it affects your ability to make decisions. Your judgment is definitely impaired. Your muscle-reaction time is slowed so that your ability to see a stimulus and react to it is dramatically slowed because the amount of time that it takes that signal to go to your brain to come back down to your hands is slowed. We know that it can affect

your speech, your -- your stagger, your -- your vision, all of those types of things as well.

Q What about the impact on divided-attention tasks like driving?

A Right. It's a -- any type of multitasking task is affected.

Q Are the results of consuming alcohol predictable in individuals? Are there uniform effects, I guess?

A There are. And alcohol is one of the best-documented substances that we have, one, because it's legal to dose people with it. So we can do studies, and we can observe different individuals at different rates. And so those tests have been done. That's part of our training to review those; to participate in observing individuals at different blood-alcohol levels and to see how they're affected by that.

Q Would a person of Mr. Russell's height and weight experience impairments like you've described at a blood-alcohol level of 0.199?

A All individuals would be impaired at that level, not just his height or weight. It takes different individuals different amounts to get to that level. But all individuals would be impaired at that level.

Q Can a person have a tolerance for alcohol that would keep them from experiencing these effects?

A No. Tolerance is -- is something that -- the behavior is -- is learned so that you -- they can complete simple tasks and -- and hide the fact that they're impaired. It's like, you know, the -- a person who's been drinking really heavily can learn to balance their steps such that they're not just totally swaying around. It's a learned experience. It doesn't mean that they can still complete all multitasking events successfully, which is, unfortunately, why some people can successfully operate a motor vehicle home; but then, on other occasions, have an accident. It's just luck that they made it home.

Q Do you have an opinion as to how an individual's ability to drive a motorcycle would be impacted if the individual has a blood-alcohol level of 0.199?

A It would -- it would be impaired in many way, more significantly than a car, because balance is so important in driving a motorcycle, where that is not something you're concerned with when you're sitting behind the wheel of a vehicle. You know, balance is -- I don't personally ride motorcycles, but know that that is a key element to riding a motorcycle successfully.

Q Could a person have a blood-alcohol level of 0.199 and -- and believe that they are not intoxicated?

A Well, your judgment is impaired. So certainly. That's why many people do drive at levels such as this:

because they -- they have an enhanced confidence in -- in their abilities, based on their impaired judgment.

Q Thank you.

CROSS-EXAMINATION

BY MR. MOORE:

Q Ma'am, let me ask you this question: Do you know anything at all about how this accident happened?

A I have read the deposition of Mr. Russell.

Q And you also talked with the lawyers for the insurance company; is that correct?

A Somewhat. Yes, sir.

Q All right. Let's assume some facts in the record. Let's assume half a moment that my client is not a liar. Let us assume that the record indicates that my client went into a restaurant and stayed about three hours. And during that three-hour period of time, he bought some drinks for himself and some drinks for some other people. And let's assume that during that three-hour period of time, he drank three standard-pour Crown and Royal -- Crown Royals. Under that scenario, you would've expected his blood-alcohol level to be about a 0.05, correct?

A An 0.075.

Q Okay. And at that point in time, if it was a 0.075, you would not be able to say, based upon a reasonable degree of professional certainty that he was impaired,

would you?

A Well, impairment starts almost immediately. So I would argue with that. There is documentation showing that your increased level of alcohol impairment starts and goes up significantly at an 0.05.

Q Well, you would not be able to say, based upon a reasonable degree of professional certainty that he was intoxicated?

A I would agree with that.

Q All right. Now, let's assume that what is in the record is true and that based upon what he consumed, he should've had a blood-alcohol reading of somewhere around 0.75 [sic]. Can you give us any explanation as to what might alter the test to have it come back and read something that we know could not possibly be the truth?

A There is nothing medically that they should've been able to give.

Q Your test is infallible, right?

A It's pretty close. And -- and, in fact, there were two tests given that came up with the same result.

Q Both tests totally infallible, right?

A Nothing's perfect. But we take ---

Q Exactly.

A --- every step ---

Q All right. Well ---

A --- to ---

Q --- so what ---

A --- try to ---

Q --- I want -- I want you to tell me is: On those things which are possible that would've made it read wrong, tell me what they would be.

A (No audible response.)

Q Let me put it to you this way: We know, based upon the facts in this record, that the test can't be right if my client is not lying. So if my client's not right -- not lying, we're about a 0.075. Assuming my client's telling the truth, give me every single scenario is a differential diagnosis that would basically give us a reason why this test is wrong.

A I would say that the test is not wrong. I -- there's different ways that he could get to that level without -- I mean, he could've drank stiffer drinks than he thought he was drinking.

Q Well, of course, we don't have any indication to prove that, do we?

A We do know that he had to consume enough alcohol to get to this level. And you couldn't do that with just three normal drinks.

Q Well, give me any other way. So you're telling the me the test couldn't be wrong?

A I'm ---

Q Impossible for the test to be wrong? And yet if he's telling the truth, it's got to be wrong. What I want you to tell me is: How could the test possibly be wrong? You say it can be. Tell me how.

A It can't be on my -- I mean ---

Q Can't ---

A --- we'd ---

Q --- be. It's infallible.

A No, sir.

Q You ever hear of somebody ---

MR. KRISTINIK: Objection ---

Q --- wanting to ---

MR. KRISTINIK: --- Your Honor. Let the witness answer the question.

A If I can tell you that we ---

THE COURT: Okay.

A --- take ---

THE COURT: Hang on.

A --- multiple steps ---

THE COURT: Hang on. Hang on. Hang on. Rephrase that question and let her answer and then go to your next question.

Q I mean, is the test infallible?

A I would say nothing in life is infallible.

Q So the answer to that question is "no," all right?
A Certainly.
Q All right. What I want you to do is to tell me the things that you can think of that would make the test wrong.
A From an analytical standpoint, I -- I don't know of any because I know that we did the checks to make sure this correct sample was -- was tested. So we -- it was tested three times in my laboratory and all three times got the same result. So it wasn't just one test. If we only ran it once, I would say maybe we could make a mistake. But it was tested three times in our laboratory and therefore ---
Q Is it possible that the subject matter that you had had been contaminated before you got it?
A I'd highly doubt it. It was sealed. It had the evidence seal over the top of the tube whenever we received it. There was no indications that it had been tampered with.
Q That's possible, isn't it?
A I -- I guess, if ---
Q All right.
A --- someone had the intention to perfectly spike a sample.
Q It might be mislabeled? Might ---
A That -- that would be a possibility.

Q It might have gotten some form of contamination in it at the time the blood was drawn?

A No, sir. We have sodium fluoride and potassium oxalate in the tubes to prevent any type of contamination like that from happening.

Q But if it gets into the sample as it's coming out of the defendant, it's certainly possible to get in that way?

A But our -- our kit that they use to collect this blood contains nothing that has ethanol in it.

Q But you don't know if there had been ethanol put on him by the ambulance drivers. You don't know if he had some sort of a rubdown. You don't know what substance he had been given by the ambulance drivers. You don't know any of that, do you?

A I don't -- they -- they just typically do not use ethanol.

Q Well, they typically don't. But they've got it in the ambulance, don't they? They got alcohol in an ambulance, don't they?

A The alcohol that they have is isopropyl alcohol, which is a totally form.

Q All right. Well, again, assuming my client was telling the truth, assuming that all he had was three drinks, standard pour, 1 ounce free pour, that's the standard pour, isn't it, 1 ounce?

A One ounce is. Yes, sir.
Q Assuming that he had three standard pours, 1 ounce over three hours, ain't no way he'd have read what your test showed, right?
A He should not have, unless ---
Q So ---
A --- he weighed a very low amount.
Q So either he's lying or there's something wrong with your test, right?
A That's what it looks like.
Q Do you know for sure which of those is true?
A I do these tests every day, and I'm pretty sure that we would -- we get them right.
Q Didn't ask you what you believe. Do you know for sure which is true?
A Again, I -- I -- I stand behind my test.
Q Do you know for sure which is true?
A No one -- no one knows for certain, I guess, if you're asking if I know what he drank. I don't know what he drank.
Q You also stand behind your opinion, though, that if he drank what he says he drank, he would not have been under the influence of alcohol?
A He would've been under the influence. He would not have been ---

Q --- intoxicated?

A --- above an 0.08.

Q Yeah. And, of course -- I want to make sure I understand this. You've seen his bill from Carolina Wings, right?

A I have. It's right here.

Q Even if he had chugged everything on that bill that he paid for, he wouldn't have gotten to a 0.199, assuming standard pour, would he?

A No, sir, he would not have. It'd have been slightly under.

Q And the assumptions you make are that he would have had the equivalent of alcohol of having chugged 12 1-ounce shots and then got on a motorcycle?

A Yes, sir.

Q Do you know of any living human being who is capable of chugging 12 1-ounce shots of liquor without throwing up?

A Unfortunately, we see it quite often.

Q All right. But those would basically be heavy drinkers, right?

A Yes. If you're going to chug 12 ounces of liquor, I would think that that would be a heavy drinker. Yes, sir.

Q All right. Now, the record indicates that my client is simply a social drinker. So if he had done what you say -- assuming the record's accurate and he's just a social

drinker, if he had done what you say he would've had to do to get to your level of alcohol, he would've been throwing up immediately upon consuming the alcohol, wouldn't he?

A No, sir. You don't always throw up.

Q He'd have been sick?

A He would've been highly intoxicated.

Q All right. Now, you say these tests are just -- they're -- they're accurate, right?

A Yes, sir.

Q If I were to test ocular fluid, would you expect the exact same result?

A No. Because ocular slightly lags behind blood alcohol whenever it's being distributed through the body. And it's slightly higher whenever it's being eliminated.

Q How about breath alcohol? Would you have expected the exact same result?

A Breath alcohol is a lower estimate than the blood. The blood is what's the most accurate. It's what's circulating to the brain at the time it's drawn.

Q I'm just asking, ma'am. Would you expect it to be the same or different with a -- with a breath-alcohol test?

A It would be within 5 percent if it was given at the same time.

Q So if I gave three tests to test blood alcohol or to test the amount of alcohol in -- in the bloodstream, I

would expect three different results?

A Well, ocular is not a blood test. It's a different test. That's an ocular test.

Q Is that ---

A You have to correct it to get to a blood level.

Q Right.

A Breath also is an estimate of blood. So you have to take that in consideration.

Q I see.

A If you repeat blood tests, they're the same. And we did do that. That's what's in my case file.

Q I see. You have any indication anywhere -- we know that he would've had to drink more than he -- more than he even paid for. He had to chug more than he even paid for to get to that level. You have anything that you've seen to indicate that he drank anything anywhere else?

A Sir, I don't -- it's not my job to determine how it gets in his body. It's my determine to tell you what we find.

Q Well, you were telling us what you found in his body and about alcohol and how it would impact people and all that sort of stuff. And you claim to be a forensic toxicologist of some sort. I'm simply asking, as a forensic toxicologist, do you have any indication that he drank the amount of alcohol somewhere else?

A Well, somebody could've bought him drinks. He could've had more than 1-ounce shots. There's a lot of scenarios. Again, it's not my job to determine that, only to determine what was in his blood at the time.

Q And he might not have consumed all the alcohol that's on his bill, correct?

A There are a lot of scenarios.

Q Right. Thank you so much for answering my questions.

A Thank you.

MR. MOORE: No further questions.

MS. HORNE: We have nothing further, Your Honor.

THE COURT: Ms. Bell, thank you for coming. You're -- you may be excused and ---

THE WITNESS: Thank you.

THE COURT: --- you're released from your subpoena.

THE WITNESS: Thank you.

(Whereupon, the witness exited the witness stand.)

THE COURT: All right. We got one more witness?

MR. KRISTINIK: Yes.

THE COURT: In the ---

MR. KRISTINIK: Connie Collins will come tomorrow at ten o'clock. We also have two witnesses we just want to present by deposition. We would like to just tell you which ones that those are and give one minute on each one what each deposition means just to save Your Honor some

time. We don't want you to have to read every single page.

MR. MOORE: I'm not sure what depositions he's talking about. I thought they were all in evidence.

MR. KRISTINIK: They are all in evidence. But we wanted to tell the judge which witnesses we are presenting ---

THE COURT: And can't you ---

MR. KRISTINIK: --- by deposition.

THE COURT: --- do that by notice of deposition excerpts? Under the rules it's these excerpts we intend to introduce and give him 24 hours' notice and he's got -- you got it in marked exact page? They're all, but ---

MR. MOORE: They're -- they're already in. If he'll just make the points that -- that -- if he want -- I think they're already all in anyway. But I have no problem with him writing up the points -- the particular pages he wants the Court to see. But I -- I would, I think, have objection to him, you know, trying to explain what the depositions say. I think they ---

THE COURT: Yeah.

MR. MOORE: --- speak for themselves.

MR. KRISTINIK: Your Honor, if I could ask, do -- at the conclusion of presentation of the evidence, are -- are you going to want counsel to submit proposed findings of fact, conclusions of law, or are you going to want some

other type of written summation of positions?

THE COURT: I hadn't decided.

MR. KRISTINIK: Okay. And -- and -- and that's why I was suggesting that, you know, we give you, you know, a minute or two on -- on the -- the two depositions that we're offering instead of bringing live witnesses. But -- but I'm happy to forgo that if there's going to be some other form that you want in writing.

THE COURT: Well ---

MR. MOORE: The live witness that he says he's bringing tomorrow, her deposition's already in evidence too. I don't even know we got to come back. It seems to me like the -- the depositions are in evidence. The Connie Collins deposition -- she's not going to say anything different than she said in her deposition, I don't think.

THE COURT: And what is she testifying to?

MR. KRISTINIK: She was the other driver. The -- her credibility is absolutely critical. We think it's very important that Your Honor actually see her in person. Her story will be different from the plaintiff, and it's going to -- it would be need -- something you need to see in person.

THE COURT: Okay. We'll ---

MR. MOORE: If he wants to say something tomorrow about the depositions that are in evidence, I don't care.

THE COURT: Okay.

MR. MOORE: Fine.

THE COURT: I mean, we'll take a brief comment on any of them. And likewise, if you're utilizing any deposition -- I don't think you are -- but ---

MR. MOORE: Uh-huh.

THE COURT: --- same -- same latitude. That would be fine. So ten o'clock tomorrow?

MR. MOORE: Thank you, sir.

THE COURT: All right.

MR. KRISTINIK: Thank you, Your Honor.

(Whereupon, the proceedings were adjourned at 3:15 p.m.)

TRIAL DAY 2 - 12/21/12

(Whereupon, the proceedings were resumed at 10:06 a.m.)

THE COURT: All right, Mr. Kristinik.

MS. HORNE: Your Honor, we'd like to call Connie Collins to the stand.

THE COURT: All right. Ms. Collins, come around here. Clerk of court will swear you.

(Whereupon, the witness came forward.)

CONNIE COLLINS, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. HORNE:

Q Good morning. Can you please state your name for the record and spell your last name.

A Connie Lynn Collins, C-o-l-l-i-n-s.

Q Ms. Collins, where do you live?

A 1124 Starcrest Road, West Columbia, South Carolina.

Q Are you a member of any clubs or churches?

A Christian Life Church on Bush River Road.

Q Where did you go to school?

A Sloan School and then Central Carolina Technical College.

Q What degree did you get you get from Central Carolina Technical College?

A An associate's degree in nursing.

Q Are you a licensed practical nurse?

A I am.

Q What's your current job?

A I currently am doing medical billing at Intertech Medical Services, and I'm a birth assistant at Covenant Birth Center in West Columbia.

Q What were you doing the evening of June 18th, 2008?

A I was driving home from Christian Life Church on Bush River Road in -- in Columbia. I was driving home. I was getting -- I had dropped my kids off, and I had an exam the next morning. So I had -- a neighbor was going to bring them home so I could go home early and study.

Q Were was the wreck that happened that night?

A On the exit that I live on, Exit 115 off of I-26.

Q How many times do you think you've driven on that exit?

A Unfortunately, several times a day every day.

Q Tell me about what happened from just before you got in your car that night until the wreck.

A Okay. I had dropped my boys off in the gym and let my neighbor know that I was going to go ahead and go home, as we had already agreed. And then I got in the car and started on I-26 just like normal and headed home.

Q Then what happened when you approached the exit to get off to go home at 115?

A I reached over to put my cell phone down into the little middle console in my car and -- sort of towards the front middle. And I didn't -- I didn't look at it. I kept my eyes on the road, but I dropped the cell phone. So it went underneath my -- my foot -- my right foot, which was on the gas.

Q It was under your gas pedal?

A It was.

Q So then what did you do?

A So I thought that it would not be good to keep driving like that. So I pulled over. The way the exit ramp goes is I-26 is here; the exit ramp is to the right. And so I pulled off in between the two so that I wasn't on the highway and I wasn't on the ramp. There's a large grassy median there that sinks down. And so I went into that.

Q You stopped your car in that grassy area?

A I did to receive -- to retrieve my cell phone out of the floorboard.

Q Were you fully stopped?

A I was.

Q Was your foot on the brake?

A It was.

Q Were your brake lights working?

A Yes.

Q What were you doing just prior to the impact of the

motorcycle?

A I reached down with my right hand, picked up my phone, put it in the passenger's seat, and had my left hand on the steering wheel and my right hand on the gearshift and my foot on the brake. And I looked in the rearview mirror to see if anybody was coming on the exit. And that's whenever I saw the headlight.

Q You saw Mr. Russell's headlight as it approached the rear of your vehicle?

A Yes, ma'am.

Q How long have you -- how long had you been stopped before you got hit?

A I would guess less than a minute because I just reached down in the floorboard, put in the passenger's seat, and got ready to back up. So less than, I would imagine, 30 seconds.

Q Had you slammed on brakes to stop your car?

A No.

Q Where did the motorcycle strike your car?

A The right-rear well.

Q Did you hear any brakes or screeching before you got hit?

A No.

Q Immediately after you felt that impact, what happened next?

A Well, of course, it threw me forward and then the -- I don't know what you call that -- but the -- the equal and opposite reaction of that sort of -- to the right side and backwards. And I saw Mr. Russell go to the right of my car. And I started screaming and ---

Q Did you move your car?

A No.

Q Okay. You saw him move past your car?

A Yes.

Q Was he wearing a helmet?

A No.

Q Where was the motorcycle after it hit your car?

A Well, at the moment that he hit my car, I couldn't see the motorcycle because it kind of went -- you know, skidded off to the right and hit the guardrail. But -- so I only saw him go by me. I didn't see the motorcycle until I got out of the car.

Q You -- the next thing you did was get out of your car?

A Yeah. Other than scream.

Q When you got out, what did you do?

A I looked to make sure nobody was coming down the exit and -- because it's a dark exit. There's no real lighting there. So I ran over to him. I was trying to compose myself so that I didn't alarm him any more, because, being in nursing school and almost finished, I was a little

worried about shock. So I wanted to make sure that I was assessing his injuries and calling 911 and doing all of that, you know, without moving him, but he was in the middle of the exit ramp. So ---

Q Did you ---

A --- I was trying to look for safety.

Q Did you talk to Mr. Russell?

A I did.

Q Was he able to speak to you?

A He was.

Q What did he say to you?

A He just kept saying, "I didn't see her. I didn't" -- no -- "I didn't see the car until I hit the car."

Q What else did you observe about Mr. Russell's condition?

A There was an injury to his leg that looked pretty bad. Again, I didn't want to move him. So I just assessed what I could see on his body. His -- his leg was obviously injured. But that was the only thing that I could see, other than he wasn't really -- he was coherent but not totally. He was a little -- like he just kept saying the same thing over and over again and, of course, the -- the smell of alcohol.

Q You could smell alcohol on Mr. Russell when you were at his side?

A I could.
Q Was there anyone else at the scene?
A No. Another couple stopped right after it happened, but they weren't on the exit ramp. They were going down I-26 when they saw it happen. And they just stopped long enough for me to call 911 and make sure somebody was on their way, and then they left.
Q What was the weather like when this accident happened?
A It was clear. It was dark.
Q With the car -- your car parked on the side of the road, could a -- a vehicle have driven past it on the exit ramp?
A It could have, except for where Mr. Russell landed was in the -- in the only portion they would've had to drive on the exit ramp. I mean, he pretty much landed right in the middle.
Q Did you do anything else at the accident scene?
A Steered a few cars away because, again, it was dark and I was concerned that somebody would not see him and not see me in the roadway beside him. So I was afraid that somebody would hit us. I called 911 and reported the accident, and they said that somebody would be on their way.
Q What'd you do after you left the accident scene? Did you go to the ER?

A I did eventually. Again, I had an exam the very next morning. And unfortunately, nursing school is probably kind of like law school. There's no tolerance unless you're the one who's been admitted to the hospital or it -- unless it's your funeral, they're -- they're not interested in why you're not there.

So I did have my boyfriend drive me to the airport, which was the closest rental car place that I could think of that would be open. And my insurance company had reminded me that a rental car place was close by in the airport. So I went there to -- to rent a car. And about that time when I was standing in front of the agent to rent the car is when -- I guess all the adrenaline kind of wore off, and everything started hurting and I pretty much hit the floor.

Q Did you get a ticket ---

A I did.

Q --- that night?

What was the ticket for?

A Oh, goodness. I believe it was -- I can't remember the technical wording. But it was for being stopped in a place that it's not a median that you're supposed to stop in. It's not an emergency lane, in other words.

Q Did you go to court for your ticket?

A I did.

Q What happened at court?
A I asked for a jury trial. And I was found not guilty.
Q Did a jury actually hear your case?
A Yes, ma'am.
Q You presented evidence about what happened that night?
A Yes, ma'am.
Q And Trooper Harmon presented evidence about what happened?
A Yes, ma'am.
Q And what did the jury find?
A That I was not guilty.
Q What about Mr. Russell's ticket? Were you at court then?
A I was.
Q Do you know what happened with that ticket?
A Yes, ma'am. Basically, the -- his attorney, Dick Harpootlian, had -- had the trial rescheduled. And Trooper Harmon was brand new. I -- we were his first accident. And he did not know that if the trial is rescheduled, that particular courthouse will not reschedule your witnesses again. They schedule them the first time and that's it. So he was not aware of that. And so Mr. Harpootlian used that to have the ticket dismissed on a technicality.
Q Were there any other lawsuits related to this wreck?
A Yes.

MR. MOORE: Objection, Your Honor, as to relevance.

MS. HORNE: Your Honor, I think that this information goes to -- between the two of these parties, who was more responsible for the causation of the wreck.

MR. MOORE: Your Honor, I can't imagine how the fact that one party may have sued another would have any relevance in fact to this particular case.

THE COURT: Let's don't delve into that. I mean, I -- I don't know that's an issue for me. But y'all certainly have presented a lot of evidence on that.

MS. HORNE: I think that's all the questions that I've got.

THE COURT: All right.

CROSS-EXAMINATION

BY MR. MOORE:

Q Good morning.

A Good morning.

Q Ma'am, I understood your testimony is that the way things were, you said you stared -- steered the car away. Do you recall saying that?

A I steered the car into the grassy median in between the ramp and the highway. Yes, sir.

Q The -- the -- the -- the -- the questioning there was after the accident, you said that you steered the car away.

A No, sir.

Q You did not? So you did not move your car after the accident?

A Correct. It -- it wouldn't have moved had I tried. But I didn't know that because I hadn't tried.

Q So we know that when the trooper arrived, your car was in the position it was in at the time of the accident?

A No, sir. His motorcycle, when it hit my right-rear well, it moved my car and his motorcycle. But where it came to rest is where it was when the troopers came.

Q Right.

A Yes, sir.

Q But after the accident what you're telling me is that the motorcycle impact was so hard that it actually moved your car?

A Yes, sir.

Q Are we talking about inches or feet that your car was moved by virtue of the impact with the motorcycle?

A I'm not sure. I wasn't really measuring. But it was definitely moved.

Q Well, okay. But, I mean, I'm trying to say was -- you -- you were there that night, correct?

A Yes, sir.

Q You know where your car was stopped?

A Yes, sir. In ---

Q You know ---

A --- the grass.
Q --- where your car wound up?
A Yes, sir.
Q You saw it, right?
A Yes, sir.
Q Was your car moved as far as from this table to the rail by being hit by a motorcycle with it stopped?
A No, sir. I wouldn't imagine so.
Q Would it have been hit as far as from the table to this chair?
A Yes, sir.
Q That would be, what, about a foot?
A I'm going by your measurements, I guess.
Q That's about a foot, isn't it?
A Seems reasonable.
Q It's -- all right. So we know that when the motorcycle hit your stopped automobile, it moved it about a foot from where it had been at the time of the impact. Sounds about right, correct?
A That's your estimation. And again, I didn't have a tape measure with me. But ---
Q And, of course, you pulled off the road. And when you did, you put your car into park, right? So your car was in park at the time of the collision?
A I believe. I thought I had put it in park. But my

foot never left the brake for sure because I intended to back up and get back on the ramp and go home.

Q Your intentions, ma'am, was to back up on a controlled-access highway?

A Well, the ---

Q Is that ---

A --- only ---

Q --- what you're ---

A --- way ---

Q --- telling -- is that what you're telling me?

A The ---

THE COURT: Let her answer.

A The only way to get back on the ramp, because I was in between the two -- the highway and the road -- so the only -- the highway and the ramp. So the only way to get back on the road would've been to get out of the grass. So I would've had to slightly back up and get on the ramp.

Q So you're coming -- well, my question is: So -- so you do not know if your car was in park or not at the time of the collision, correct?

A I believe it was.

Q And the collision, when it moved your car, would've moved it further to the left, not further to the right, correct?

A It did not. It moved it back to the right.

Q Moved it to the right? Okay.
A At an angle.
Q Well, ma'am, if you're struck at an angle in the right-fender well ---
A Yes.
Q --- explain to me, under the law of physics, how being struck in the right-fender well moves your car to the right.
A Okay. The wheel wells in my car apparently are a crumple zone. And it did what it was supposed to do. It crumped around -- it crumpled. And his tire was caught in the middle of it. And it moved my car -- it yanked it back and to the right a little.
Q Back -- yanked it back and to the right a little? Okay.
A Yes, sir.
Q Well, explain this to me: You understand that when you have an emergency on a controlled-access highway, what you're supposed to is to pull off to the right as far as you can, correct?
A Yes, sir.
Q But you pulled off to the left?
A Correct.
Q Now, when you pulled off to the left, my client would have been coming, then, from your right, correct?

A He would've been. Yes, sir.
Q Explain to me, if the motorcycle is coming from your right and you're to the left, how, instead of hitting you in the rear, he actually hit you in the side at the point of the fender well?
A He wasn't coming straight onto that exit ramp, apparently.
Q Do you know? You didn't see him before the impact, did you?
A I did. I saw his headlight. I didn't see the whole motorcycle. I just saw the one big headlight.
Q So you were stopped over to the left?
A Yes.
Q And yet you got hit in the right-fender well?
A Yes, sir.
Q You were not hit in the rear?
A Correct.
Q All right. And you had been parked there for about a minute before the collision happened?
A Less than 30 second, I would imagine. I wasn't timing it, again. But I would imagine less than 30 seconds, the time it took me to reach -- get my cell phone, put it on the passenger's seat, and check my rearview mirror.
Q Ma'am, how far had you ridden with the cell phone on your console?

A Not -- I hadn't ridden with it at all. I was putting it on the console and it fell. And I pulled over as soon as I got to the exit.

Q Oh. You were putting the cell phone onto the console at the same time you would have been entering the exit ramp?

A Okay. Not exactly the same moment. A little -- there's -- in between exits, I can't pull over on the right. Again, on this exit I couldn't pull over on the right, because had he pulled over on the right, there wouldn't have been enough of an emergency lane. There's no real emergency lane there, in other words, on the right.

Q Well, ma'am, you've told me that it fell off at the same time that you were putting it there. And you told us that you were putting it there as you were on the exit ramp. You've told us both those things, correct?

A I apologize. It was on the floor, which is why I pulled in between the two.

Q I'm wanting to know if what you testified to is the truth: that it fell as you were putting it on the console.

A Yes. It fell as I was putting in on -- attempting to put it on the console.

Q And you've told us, too, that it fell as you were coming on the exit ramp. You've told us that too, haven't you?

A As I was approaching the exit ramp. I apologize. I'm a little nervous. This is my first time doing this.

Q And that's why you were just mistaken about what you testified to, correct, because you're nervous?

A This is a little nerve-racking. Yes, sir.

Q And that's -- and that's why what you said was just wrong just a moment ago, because you're nervous?

A I was approaching the exit ramp, to ---

Q I see.

A --- be clear.

Q But -- okay. I understand that. And so what you previously testified just wasn't -- wasn't accurate is -- and -- and what you've now testified to is accurate, right?

A To be honest, I have never split hairs this much. So it -- as I was approaching the exit ramp, I put the phone there.

Q I -- I understand that. And I'm not fussing at you. But we -- we now know you've given us two different versions of that. And the reason why that is ---

MR. KRISTINIK: Objection ---

Q --- is that ---

MR. KRISTINIK: --- Your Honor, to the way he's framing this question. That is not a question. He is characterizing the testimony.

MR. MOORE: I had not finished the question, Your

Honor.

THE COURT: All right. Well, just ask her a question. And we all -- ma'am, just relax. If you want some water, you can have some water.

THE WITNESS: That would be great.

THE COURT: All right. You've got some right there.

(Off the record briefly.)

Q Ma'am, the reason why you've given us two versions is because you're nervous; is that correct?

A That and we're talking about a distance of -- I don't even know if it would be a foot.

Q Okay.

A I didn't really see that it was that much of a difference, to be ---

Q When ---

A --- honest.

Q When you pulled off there to the left instead of going to the right to pull off, just you decided to go to the left. When you did that, did you pull off at an angle?

A Well, you have to, to get around this -- the sign there for the ramp.

Q Sure. The only way to pull off to the left there is to be angling to the left, right? You'd have to.

A But I straightened my car up.

Q All right. So you pulled off to the left at the sign.

And then you straightened it back up, correct?

A So that my wheels were pointing forward.

Q Your -- well, the wheels are going to always be pointing forward, whether they point to the left, to the right, but always pointing forward, aren't they?

A Not to either side is what I meant by "forward."

Q I see. So you -- you pulled off to the left by the sign at an angle, and then you straightened your car back up to be parallel with the roadway is what ---

A Yes, sir.

Q --- you mean?

All right. So then, for the motorcycle to have hit you in the right front -- I'm sorry -- the right rear ---

A Yes, sir.

Q --- he certainly ---

A Wheel well.

Q --- couldn't have been coming up the grassy area there because the sign would've hit him, right?

A Had he been able to see that I was stopped and been able to see that I was not on the road and not on the exit ramp, then ---

Q But we know there's a sign that was immediately behind you, because you had to go to the left to avoid that?

A Behind and to my left.

Q Right. The sign was behind you and to your left?

A Yes, sir.
Q All right. So what you did was you had -- which we know you had to angle to the left to get off the roadway to avoid that sign, right? You've told us that?
A The sign is to the -- it may be easier if I draw it for you.
Q That's okay. Just describe it to me. The sign ---
A Okay.
Q --- is to your left.
A The exit ramp goes to the right. I-26 goes to the left. There's a sign that kind of sits in the middle in between I-26 and the ramp to -- with the little arrow that points to the ramp. I went to the right of the sign, waited until my wheels all sunk down in the grass to make sure I wasn't on the pavement, and stopped the car.
Q Right.
A So ---
Q So ---
A --- the ---
Q --- then, you would've been basically parallel to the roadway with the sign directly behind you?
A Not directly. Back and to my left.
Q Back and to your left?
A If I ---
Q And how far?

A --- had backed up, I wouldn't have hit the sign, in other words, if ---

Q Well, how ---

A --- that ---

Q --- far ---

A --- helps.

Q How far would you have been up from the sign? A car length?

A At -- I would say that a car length is fair. Yes.

Q All right. And you -- so what you did was you went to the left to avoid the sign and straightened back up for about a car length and then you stopped?

A Okay. I went -- I did not go to the left of the sign. The left of the sign would've meant that I was still on I-26. I went to the right of the sign. The car -- the sign was then in my back-left of my car.

Q About a -- about -- about a car length ---

A Yes ---

Q --- right?

A --- sir.

Q So if the motorcycle had been coming the same path you had taken, he would've hit you directly in the rear?

A Correct.

Q If the motorcycle had been coming to your left, he'd have hit the sign?

A Correct.
Q So then, we know the motorcycle did not hit you from either the rear or the right rear or left rear?
A He hit me in the right-rear wheel well at an angle.
Q Right. Well, tell me this: If your car is parallel to the road, how was it possible for the motorcycle to have hit you at an angle?
A I'm parallel to I-26, not the exit ramp.
Q Oh. You were parallel to I-26, not the exit ramp?
A Yes, sir.
Q So then, you would've been sitting at some sort of an angle in regard to the exit ramp that you were trying to take?
A I was off to the left of the exit ramp. And yes. If you were straightening out the exit ramp and saying am I parallel or am I at an angle, yes. I was at an angle to the ramp, but parallel to I-26.
Q Describe the angle that you were at.
A The ramp -- here's I-26. I'm sorry. I don't know how else to do it other than ---
Q That's ---
A --- hand ---
Q --- okay.
A --- motions. The exit ramp goes off and then it starts curving. It kind of snakes around.

Q It does. Yes, ma'am.
A And I was pulled in between I-26 and the ramp around here. But as -- so the angle of the ramp would go this way ---
Q Would your ---
A --- at that ---
Q --- rear ---
A --- particular part.
Q Would your rear end have been closer to the exit ramp, or would your front end have been closer to the exit ramp?
A My rear end.
Q All right. So then, in regard to the exit ramp, your car would have been cocked to the right like that, with the right closer to the exit ramp and the left closer to the grass?
A Sorry. Can you say that one more ---
Q Sure.
A --- time? I'm trying to visualize it.
Q Here's the exit ramp.
A Yes, sir.
Q If you're cocked like you said, with the rear end closer to the ramp, it would've had to been like that, right?
A Yes, sir.
Q Your rear wheels would have been closer to the exit

ramp than your front wheels?

A Slightly. Yes, sir.

Q All right. So we know that you're sitting there in an angle, cocked like you have told us?

A (Nodded head up and down.)

Q Now, if what you're telling us is true, with the car cocked like that ---

A Yes, sir.

Q --- and the laws of physics applicable to the situation, explain to me it is humanly possible for the motorcycle to have hit the rear-fender well.

A I'm not a physics professor. But I can tell -- I'm just telling you how the car moved and where he hit me.

Q You can tell me where the car moved and where they hit. I understand that. So you know how your car moved, and you know what part of your car was hit ---

A Yes ---

Q --- right?

A --- sir.

Q However, with your car cocked like you said, if you were cocked like you said where you said, it's physically impossible for the motorcycle to have hit that car unless it came straight into it; is that right?

A I'm -- again, I'm not a physics professor. I'm just telling you what happened.

THE COURT: Isn't her testimony consistent with the accident report? I mean, that's exactly how the trooper's got it drawn.

MR. MOORE: It -- it's -- it -- it's ---

THE COURT: I mean, it ---

MR. MOORE: --- it -- it ---

THE COURT: --- it's -- it's virtually identical with nontechnical testimony.

MR. MOORE: And -- and what ---

THE COURT: Uh-huh.

MR. MOORE: --- what I'm trying to get to, Your Honor, is exactly that point: It is exactly consistent with the accident report, which basically shows -- the -- the problem I have is this: She's trying to explain to the Court that -- that -- that it's not consistent with the accident report. I believe her testimony now is that it's totally consistent with the accident report, which is what -- what the trooper testified to.

THE COURT: That's what ---

MR. MOORE: That's what I'm to ---

THE COURT: That's what ---

MR. MOORE: --- get to. Obviously, I have made my point. And with that ---

THE COURT: Okay.

MR. MOORE: --- I will sit down.

THE COURT: No. I mean, I -- that's what I see, and she's testified very consistently with this.

MR. MOORE: Yes, sir.

THE COURT: I mean, inartfully maybe at times because of her nervousness, but she's ---

MR. MOORE: Sure.

THE COURT: --- done fine.

THE WITNESS: Thank you.

Q Ma'am, let -- let me do ask you this.

A Yes, sir.

Q Ain't no doubt -- doubt about it; my client was laying in the roadway?

A Absolutely.

Q Hurt really bad, wasn't he?

A Well, he apparently didn't feel it as badly as he was later hurt due to the alcohol. But ---

Q So he didn't look like he was hurting, right, according to you?

A Well, he wasn't getting up. And I didn't want him to get up because, you know, you never know what kind of injuries somebody may have that's internal.

Q Right.

A But he -- he kept saying that his foot was asleep, and that was the foot that was injured -- the leg that was injured. So he didn't look at it, thankfully. I tried to

encourage him to just hang on and the ambulance would be there because I didn't want him to see how bad it was.

Q And he kept saying there at the scene that night that the reason this happened is because he just didn't see you until he hit you, right?

A Well, he didn't realize it was me that he was talking to. But he just kept saying, "I didn't see the car until I hit it."

Q Very fine. Thank you so much.

A Thank you.

MS. HORNE: We have nothing further, Your Honor.

THE COURT: Thank you so much, Ms. Collins.

THE WITNESS: Thank you.

THE COURT: You're done.

MR. KRISTINIK: And, Your Honor, she may be dismissed from the Court?

THE COURT: Sure.

THE WITNESS: Thank you.

MR. MOORE: No objection.

THE COURT: Okay.

(Whereupon, the witness exited the witness stand.)

(Off the record briefly.)

THE COURT: Anything else?

MR. KRISTINIK: Your Honor, Ms. Horne is going to make just very brief comments about two of the depositions that

we're offering in lieu of live testimony. And then we'll just want to speak briefly about a couple of exhibits, and -- and then logistics, and then we would rest our case.

THE COURT: All right. Go ahead, Ms. Horne.

MS. HORNE: First, I'll provide a very brief overview of the testimony of Trooper Harmon for his deposition and with his appearing here today. He testified that Ms. Collins's car was in the grassy area on the left between the exit ramp and the road and almost entirely out of the road, maybe a half a foot over the white line. Her lights were on. And the other car -- and her car was visible.

Debris and scrapes on the roadway showed that the accident happened right where the troopers found the vehicles at the accident scene. Trooper smelled odor of alcohol on Mr. Russell at the emergency room when he arrived after leaving the scene of the wreck. Mr. Russell denied having had alcohol.

The SLED blood sample was drawn according to procedure and properly handled in the chain of custody. Mr. Russell's intoxication caused the wreck, as indicated in the collision-report form. And a car could have been able to safely navigate past Ms. Collins' vehicle on the side of the road.

THE COURT: All right.

MS. HORNE: Next I'll provide a brief summary of the

30(b)(6) deposition of Lexington Medical Center. Ms. Wendy Knight, which is the lab manager of the Lexington Medical Center Lab provided this information. She explained in her deposition that proper collection and testing procedures were used in the collection and testing of Mr. Russell's blood sample. The chain of custody within the hospital was appropriate and that the results of an ETOH level of 0.232 were generated as the result of this testing procedures and was automatically inserted into his medical records through the computer system, not transcribed or filed by an individual.

THE COURT: All right. All right. I'm going to -- I'm going to offer Mr. Moore, likewise, the same opportunity: If he wants to make note of anything particular within the record that's -- I've not seen quite yet. So it's there; I'm going to see it. But ---

MR. MOORE: I -- Your Honor, I -- I believe that the -- the trooper's testimony is consistent in the deposition with ---

THE COURT: Seems consistent.

MR. MOORE: --- what ---

THE COURT: Thus -- thus far, I didn't hear anything very contradictory.

MR. MOORE: It's ---

THE COURT: It's ---

MR. MOORE: It's basically that the other driver was where was supposed not to be and was one of the causes of the accident.

THE COURT: Okay.

MR. MOORE: But yes, sir. Thank you.

THE COURT: All right.

MR. KRISTINIK: A last couple things: With respect to exhibits, there's a couple of additional exhibits we would like to add. One is the C.V. of Dr. Richardson. And I'm happy to show this to them, just to make sure they have no issue with that. That would be exhibit ---

THE COURT: He was qualified, though, wasn't he? Didn't we qualify him as an expert?

MR. KRISTINIK: Yeah.

THE COURT: The young doctor, the -- the -- the ---

MR. KRISTINIK: Yes.

THE COURT: --- the guy that -- that done all the studies out west on ---

MS. HORNE: Yes, sir.

THE COURT: --- poisoning and sort -- different sorts of things?

MR. KRISTINIK: Yes, Your Honor.

THE COURT: Okay. Yeah. He was qualified.

MR. KRISTINIK: Okay. And then, Exhibit 27, we produced these records to opposing counsel, I believe,

earlier this week. But it is the forms filed by Pennsylvania Life in 1991 with the South Carolina Department of Insurance and stamped by the South Carolina Department of Insurance as approved, just to show the Court that those were filed, approved forms. And one, of course, is the form with the intoxication exclusions in it and which, of course, matches the specimen policy that we've marked as an exhibit in this case. And we would like to submit that as Exhibit No. 27.

MR. MOORE: Your Honor, does -- does -- does counsel urge upon the Court the fact that a form is approved, that that, in and of itself, makes the language nonambiguous? I'm -- I'm not sure of the reason. I mean, the -- it's already in evidence that they had the form approved. But I'm not sure what legal import they have urged upon the Court that that happens. Whether something is ambiguous or not or complied with, to me, is a legal question for the Court. The fact that the State of South Carolina may have approved a form or that the -- the legislature is capable of -- of writing ambiguous statutes, which, I believe, from time they may.

Certainly, the state department of insurance is capable of approving an ambiguous form. They submitted it. But I'm ---

THE COURT: Yeah.

MR. MOORE: --- I'm not sure what relevance it has. And I think it's already in the evidence that they had the forms submitted and approved by the department of insurance.

THE COURT: Well, if they weren't approved, your argument would be totally different.

MR. MOORE: Oh, sure. But, I mean, if he wants to put that in evidence, I got no problem.

THE COURT: Okay.

MR. MOORE: Okay.

THE COURT: That's fine. I mean, I -- I would expect it.

MR. KRISTINIK: Okay. Well, Your Honor, with that the defense will rest its case. I -- I do want to work with opposing counsel to make sure that we inventory all the exhibits that we've given in stacks and -- and hand them -- how would you like us to hand them to any person in particular or leave them on the table?

THE COURT: Let's make certain -- do we have the inventory from the first court reporter, Ms. Davenport? Is her list in there?

THE COURT REPORTER: I don't -- I've never -- I have not touched the exhibits. I don't know what's in there. I have not seen any inventory, so I'm ---

THE COURT: All right.

THE COURT REPORTER: --- I'm unsure as to ---

THE COURT: The law clerk and I will go through it with y'all.

MR. RILEY: As -- as far as the plaintiff's exhibits, Your Honor, the court reporter, we did provide her a list the first day. It still matches. And all those are what's in that box right there.

MR. KRISTINIK: Okay.

MS. HORNE: And, Your Honor, as I understand it, she actually marked that inventory list as Exhibit 1A.

MR. RILEY: That's correct.

MS. HORNE: So it ---

THE COURT: Okay.

MS. HORNE: --- should be an exhibit itself.

THE COURT: I mean, she's -- she kept them in order as we did that, even when we took the notebook apart. She had pretty good -- from what I observed. I just wondered if that list was still here. It -- but it ---

MR. RILEY: That ---

THE COURT: --- you think it is?

MR. RILEY: Okay. That's correct.

MR. KRISTINIK: I -- I wanted to match up the list to make sure everything's in there. I've got our set of exhibits. I want to make sure everything's in there and that they see all that ---

THE COURT: Okay.

MR. KRISTINIK: --- and all the depositions -- make sure we have all those for you ---

THE COURT: Okay.

MR. KRISTINIK: --- and -- before we leave today.

THE COURT: All right. Very well.

MR. MOORE: Your Honor, since this is a nonjury matter, it would be my belief that it would be necessary for the plaintiff to make a motion for directed verdict. I think it's simply a question -- in my humble opinion, it's a question of fact and how the law basically relates to those facts. I think it's factual questions, so we're happy -- and I ---

THE COURT: Well ---

MR. MOORE: --- understand ---

THE COURT: --- I mean ---

MR. MOORE: --- the Court's going to ---

THE COURT: --- the purpose of directed verdict would not to let jury hear it. I mean ---

MR. MOORE: Sure. So at this point in time, if I had to make those motions, I'd make them. But I understand the Court would deny it and basically give us an opinion based upon the facts and the law. And the Court, I think, wants -- has indicated it wants to take the time to look at the documents.

THE COURT: Uh-huh. We do. All right. Anything else, other than the inventory of the documents?

MR. KRISTINIK: Nothing further, I -- Your Honor. Is there anything else that you would like from counsel?

THE COURT: Unh-unh. No. Not at this time.

MR. KRISTINIK: Okay. All right. Well, thank you for your -- your patience and for carrying us over so that we could finish it this week.

THE COURT: I'm glad to do it. I'm going to let Mr. Riley here get involved with the inventory.

(Whereupon, the proceedings were concluded at 10:48 a.m.)

--- END OF TRANSCRIPT OF RECORD ---

CERTIFICATE

I, THE UNDERSIGNED MARYANN S. NEVERS, CERTIFIED VERBATIM REPORTER - MASTER, CERTIFICATE OF MERIT, OFFICIAL COURT REPORTER FOR THE EIGHTH JUDICIAL CIRCUIT OF THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE, ACCURATE, AND COMPLETE TRANSCRIPT OF RECORD IN THE HEARING OF THE CAPTIONED CAUSE, RELATIVE TO APPEAL, IN THE CIRCUIT COURT FOR LEXINGTON COUNTY, SOUTH CAROLINA, ON THE 20TH AND 21ST DAYS OF DECEMBER, 2012.

I DO FURTHER CERTIFY THAT I AM NEITHER OF KIN, COUNSEL, NOR INTEREST IN ANY PARTY HERETO.



MARYANN S. NEVERS, CVR-M-CM

COLUMBIA, SOUTH CAROLINA

AUGUST 10, 2014

THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS

ACCIDENT BENEFIT POLICY

This Policy provides benefits for specified loss resulting from Injury. It is guaranteed renewable. We reserve the right ot change the premium rates on a Class basis.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

YOUR THIRTY-DAY RIGHT TO EXAMINE YOUR POLICY

This Policy is a legal contract between you and the Company. PLEASE READ YOUR POLICY CAREFULLY. If, for any reason, this Policy is not satisfactory, it may be returned within 30 days following receipt. This Policy can be returned to us or to our authorized agent. If so returned, the premium paid for this Policy will be refunded and the Policy will be deemed void from its beginning.

PENNSYLVANIA LIFE INSURANCE

Home Office: Lemoyne, Pennsylvania
Executive Office: 1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
Phone: (800) 275-7366

(A Stock Company, herein called "we," "our," "us" or "the Company.")

In this Policy, the person named as the Insured in the Policy Schedule on Page 3 will be referred to as "you," "your" or "the Insured." The person named as the spouse in the Application will be referred to as "Covered Spouse." Dependents named as such in the Application will be referred to as "Covered Dependents." Definitions of certain capitalized terms are found in the Definitions section.

We have issued this Policy to you in consideration of: (1) the statements made in the Application; and (2) the payment of the first premium.

INSURING CLAUSE

We hereby: (1) insure you, your Covered Spouse and your Covered Dependents named in the Application against specified losses specified in the Policy or Rider Schedule resulting from Injury; and (2) agree to pay the benefits described, subject to the definitions, provisions, limitations, and exceptions of this Policy.

TERMS OF COVERAGE

The term of this Policy begins on the Policy Date, shown in the Policy Schedule on page 3, at 12:00 Noon, Standard Time at the place you reside. This term will end at the same time on the First Renewal Date shown in the Policy Schedule, subject to the Grace Period. You may then renew this Policy subject to the Guaranteed Renewable to Age 85 provision for equal terms beginning and ending in each case at 12:00 Noon, the same Standard Time. We will accept payment of the renewal premium then in effect according to the mode selected in the Application.

Premiums are payable directly to us or through our authorized agent. Premiums must be paid on or before the date they are due, subject to the Grace Period.

GUARANTEED RENEWABLE
COMPANY RESERVES RIGHT TO CHANGE TABLE OF PREMIUM RATES

You have the right to continue this Policy in force by the timely payment of the required renewal premium. While this Policy is so continued, we will not: (1) place restrictions on it; or (2) terminate it.

We reserve the right to change rates for policies of this form issued to persons of the same insuring Class in your state. If we do raise your premium due to a change in rates, then at least 60 days before your renewal date, we will send written notice to you at your last address as shown in our records.

DEFENDANT'S EXHIBIT

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POLICY SCHEDULE

INSURED MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC
29172-2451

POLICY NUMBER	[redacted]9360
POLICY DATE	11-19-99
FIRST RENEWAL DATE	12-19-99
ANNUAL PREMIUM	$2,889.16
MODE	MONTHLY PAC
MODE PREMIUM	$260.02

INITIAL ACCIDENT COVERAGE -- PRIMARY INSURED		EFFECTIVE DATE
MONTHLY TOTAL DISABILITY BENEFIT	$2,000.00*	11-19-99
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
MONTHLY TOTAL DISABILITY BENEFIT	$500.00*	07-19-02
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
ACCIDENTAL DEATH BENEFIT	$25,000.00	11-19-99
ACCIDENTAL DEATH BENEFIT	$75,000.00	07-19-02
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$1,000.00	11-19-99
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$4,000.00	07-19-02
EMERGENCY TREATMENT BENEFIT	$50.00	07-19-02

* TOTAL DISABILITY BENEFITS MAY END FOR TOTAL DISABILITY STARTING AFTER AGE 65 (SEE TOTAL DISABILITY RIDER)

POLICY SCHEDULE(CONTINUED)

INITIAL SICKNESS COVERAGE -- PRIMARY INSURED		EFFECTIVE DATE
MONTHLY TOTAL DISABILITY BENEFIT	$2,500.00 *	08-19-02
MAXIMUM BENEFIT PERIOD	2 YEARS	
ELIMINATION PERIOD	30 DAYS	
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$5,000.00	08-19-02
RETURN OF PREMIUM RIDER	YES	11-19-99

1900

PART ONE

GENERAL INFORMATION ABOUT BENEFITS

(1) The benefit amounts are shown in the Policy Schedule on Page 3; (2) All losses must commence while this Policy is in force; (3) Benefits for less than one month will be paid at 1/30th of the monthly benefit per day; (4) Total Disability Benefits are only payable for Insured or Covered Spouse if such coverage for Insured or Covered Spouse is indicated on the Application; (5) A Rider providing coverage for loss from accidental bodily injury must be attached to this Policy for it to be in force.

PART TWO

DEFINITIONS

These are some of the key words used in this Policy and attached Riders. They are important in describing both your rights and ours.

BENEFICIARY means the person(s) named as such in the application unless later changed. See the Payment of Claims and Change of Beneficiary provisions.

CLASS means persons of the same age covered under this Policy or similar policies of this form.

COVERED FAMILY MEMBERS means you, your spouse and your dependent children: (1) who are named in the Application; and (2) who are eligible under the terms of the Eligibility and Termination Provision.

ELIMINATION PERIOD means the period which must expire before benefits are payable. This period, if any, is shown in the Policy or Rider Schedule. Benefits are not payable for the Elimination Period. Only one Elimination Period will be applied to a Period of Disability.

HOSPITAL means a place which: (1) operates pursuant to law; (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients; (3) provides 24 hour a day nursing service by or under the supervision of graduate registered nurses (R.N.); (4) has a staff of one or more currently licensed Physicians; and (5) provides organized facilities available on a contractual pre-arranged basis.

Other than incidentally, it must not be: (a) a nursing home; (b) a rest home; (c) a convalescent home; (d) an extended care facility; (e) a hospice; (f) a place set up mainly to treat alcoholics or drug addicts; or (g) a home for the aged.

INJURY means accidental bodily injury sustained: (1) directly and independently of disease or bodily infirmity, or any other causes; and (2) while this Policy is in force.

NOTICE TO US means information we have received at our Executive Office which is written and signed by you.

PERIOD OF DISABILITY means a continuous period of Total Disability.

PHYSICIAN means a currently licensed practitioner of the healing arts. This definition excludes you and members of your immediate family.

POLICY DATE means the date on which this Policy is effective. This date is shown in the Policy Schedule on Page 3.

REGULAR AND PERSONAL CARE means a planned program of observation and treatment requiring personal attendance by a Physician. Once started, this program must be continued under the existing standards of medical practice for treatment of the injury.

TOTAL DISABILITY: TOTALLY DISABLED means that you or your Covered Spouse are unable to engage in your or your Covered Spouse's own employment or occupation during the first twelve months of disability; after the first year, Total Disability means the complete inability of you or your Covered Spouse to engage in any employment or occupation for which you or your Covered Spouse, are or become qualified by reason of education, training or experience.

PART THREE

ELIGIBILITY AND TERMINATION

ELIGIBILITY: Those who may apply to be a Covered Family Member are: (1) the Insured; (2) the spouse of the Insured; and (3) dependent children of the Insured over the age of one month and under age 19 years. If the Insured dies, the spouse, if covered, will become the Insured.

ADDING NEW FAMILY MEMBERS: Family members who are not covered on the Policy Date, may be added to the Covered Family Members. To do so, we must receive: (1) an application; (2) evidence satisfactory to us that such family member is eligible and insurable; and (3) payment of the then current premium. If the new family member is approved, a new rider covering such family member shall be attached to this Policy. Coverage under the new rider shall be controlled by its effective date. Coverage for your spouse will cease on the premium due date next following the date of divorce from you. If application is made within 60 days of

such date, we will issue to such spouse a new Policy which provides benefits not greater than those in this Policy. Other eligible dependents may be covered under this Policy or the new policy, but may not be covered under both.

A child's status as a Covered Dependent will end at noon on the first renewal date after such child's 19th birthday if neither item (a) nor (b) below applies. A child will continue as a Covered Dependent as long as:

(a) such child is: (1) attending an accredited school or college; and (2) chiefly dependent on you for support and maintenance, but not beyond noon on the first renewal date after such child's 26th birthday; or

(b) such child is: (1) mentally or physically incapable of self-sustaining employment; and (2) maintenance. We must receive due proof of such incapacity and dependency within 31 days of the date coverage would otherwise terminate for such child. The premium for such child will be at the dependent rate. While coverage is so continued, we may require proof that the incapacity and dependency still exist. Such proof will be requested at reasonable intervals, but not more often than once a year. Coverage for such child will cease on the next premium renewal date if: (1) you refuse to submit such proof; (2) the incapacity ends; or (3) the dependency ends.

If we accept a premium for anyone who is no longer eligible to be a Covered Family Member or after coverage would otherwise terminate, coverage will continue for such person during the period for which premium was accepted to the next renewal date. This continuation of coverage does not apply if such acceptance is based on a misstatement of age. We may terminate coverage on that renewal date of any renewal date thereafter.

Termination of this Policy shall be without prejudice to any continuous claim for loss incurred while this Policy is in force. The extension of benefits beyond the termination date may depend upon the continuing Hospital confinement or Total Disability and shall be limited to the duration of the benefit period and subject to all applicable provisions of the Policy and Rider(s).

CONTINUATION: However, when a non-handicapped dependent child's status as a Covered Family Member terminates, such child is entitled to have issued to him/her, without evidence of insurability, upon application made to the company, a policy with comparable benefits.

PART FOUR

EXCEPTIONS AND LIMIATATIONS

This Policy does not cover any loss that (1) occurs outside the United States of American and its territories. Canada and Mexico (any premium paid to us for any period no covered due to such territorial limitation will be returned pro-rata upon Notice to Us); (2) results from suicide or any attempt thereat (sane or insane); (3) results from any intentionally self-inflicted Injury; (4) results while in the military or naval service of any country (any premium paid to us for any period not covered due to such service will be returned pro-rata upon Notice to Us); (5) results from war (declared or undeclared), or any act of war; (6) results from voluntary participation in insurrection or riot; (7) results from mental or emotional disorders, alcoholism, or drug addiction; (8) results from normal pregnancy and childbirth, except for complications of pregnancy; (9) results from service, travel, or flight in any kind of aircraft, except as a fare-paying passenger; or (10) results from dental treatment except when such treatment results from Injury to natural teeth or gums.

You or your Covered Spouse will never be considered to be disabled from two or more disabilities at the same time.

ILLEGAL OCCUPATION

We will not be liable for any loss which results from: (1) committing or attempting to commit a felony; or (2) engaging in an illegal occupation.

INTOXICANTS AND NARCOTICS

We will not be liable for any loss which results from being: (1) intoxicated; or (2) under the influence of any narcotic unless taken on the advice of a Physician.

OTHER COVERAGE IN THIS COMPANY

If you have more than one Policy of this coverage issued by us, the Policies except the one elected by you, your Beneficiary or your estate will be void. All premiums paid for such voided policies will be returned to you or your estate.

PART FIVE

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy with the Application and attached papers, including endorsements and riders of any kind is the entire contract between you and us. No change in this Policy will be effective until approved by one of our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After this Policy has been in force for two years, misstatements in the Application will not be used to: (1) void the Policy; or (2) deny a claim for loss incurred or disability that starts after the two-year period.

GRACE PERIOD: This Policy has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period, the Policy will stay in force. If the premium is not paid within the Grace Period, the Policy will end.

REINSTATEMENT: If this Policy has ended due to an unpaid renewal premium, it will be reinstated if: (1) the premium is later accepted by us or our authorized agent; and (2) we do not require an application for reinstatement. If we do require an application for reinstatement and issue a conditional receipt, this Policy will be reinstated on the earlier of: (1) the date we approve such application; or (2) the 45th day after the date of the conditional receipt unless we have sent you written notice of our disapproval before then.

The reinstated Policy will cover only loss due to Injury sustained after the date of reinstatement. In all other respects, your rights and ours will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any premium which we accept in connection with a reinstatement will be applied to a period for which a premium has not been previously paid. It will not be applied to any period more than 60 days prior to the date of reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to us at our Executive Office. Notice should include the name of the Insured, the claimant, and the Policy Number.

CLAIM FORMS: After we receive the notice of claim, we will send the claimant our forms for filing proof of loss. If these forms are not sent to the claimant within 15 days after notice of claim, the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time stated in the Proof of Loss section.

PROOF OF LOSS: If the Policy provides for a monthly payment for a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified, unless the claimant was legally incapacitated.

PHYSICAL EXAMINATIONS: We will have the right to have a Covered Family Member examined by a Physician of our choice. Such examinations will be at our expense. They will be required when and as often as is reasonably necessary while a claim is pending or during a period for which benefits are being paid.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy for any loss other than loss which provides for a monthly benefit, will be payable immediately upon receipt of written proof of the loss. All accrued benefits for any loss for which a monthly benefit is provided will be payable monthly. Any balance remaining unpaid upon the termination of our liability will be payable upon receipt of written proof of loss. Benefits for a period of less than a full month will be paid at the daily rate.

PAYMENT OF CLAIMS: Benefits will be paid to you. Loss of life benefits are payable in accordance with the Beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. For your Covered Spouse or Covered Dependents, loss of life benefits will be paid in accordance with the beneficiary designation. If none is then in effect, such benefits will be paid to you. If benefits are payable to your estate, we can pay benefits up to $1,000.00 to someone related to you by blood or marriage, whom we

consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

CHANGE OF BENEFICIARY: You can change the Beneficiary only by Notice to Us. The Beneficiary's consent is not required for this or any other change in this Policy, unless the designation of the Beneficiary is irrevocable. A Beneficiary designated irrevocably may not be changed except with the written consent of that Beneficiary.

A change of Beneficiary will take effect on the date the Notice to Us was signed: (1) even if the Insured is not living when we receive the Notice; and (2) subject to any payment that may have been made by us in good faith before receiving the change.

LEGAL ACTIONS: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after six years from the time written proof of loss is required to be given.

AUTOPSY: We shall have the right and the opportunity to examine the body of a Covered Family Member and to have an autopsy made, at our expense, unless prohibited by law.

The autopsy must be performed in South Carolina during the contestable period, which is the first two years that this Policy is in force.

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

CONFORMITY WITH STATE STATUTES: On the Policy Date, any provision of this Policy which is in conflict with the statutes of the State in which you then reside is amended to conform with the minimum requirements of those statutes.

This Policy has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

Secretary

President

PENNSYLVANIA LIFE INSURANCE

Home Office: Lemoyne, Pennsylvania
Executive Office: 1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
Phone: (800) 275-7366

ACCIDENT TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) Injury causes Total Disability which starts within 30 days after the date of the accident and continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under the Regular and Personal Care of a Physician; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Policy Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care of a Physician continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one accident.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage, However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Policy was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if injury results in you or your Covered Spouse being confined in a Hospital as a resident patient under the Regular and Personal Care of a Physician. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for Total Disability end.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods: (a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.



Secretary



President

PENNSYLVANIA LIFE INSURANCE

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Executive Office: 1001 Heathrow Park Lane
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Phone: (800) 275-7366

ACCIDENTAL DEATH BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

If Injury results in the death of a Covered Family Member within 90 days of the accident, we will pay the Accidental Death Benefit shown in the Policy Schedule to the designated Beneficiary.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for death which results from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible f or coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

Secretary

President

PR-1903 SC

10.91

PLIC 0076

PENNSYLVANIA LIFE INSURANCE

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Phone: (800) 275-7366

ACCIDENT SURGICAL INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is a resident patient in a Hospital; and
2. The Hospital stay is for a covered Injury; and
3. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Accident Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity, except that no amount is payable for dental treatment unless such treatment results from accidental bodily injury to natural teeth or gums. If a covered surgical procedure is performed on an Insured who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Accident Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one accident.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for covered surgical procedures resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

Secretary

President

PR-1904 SC

10.91

PLIC 0077

ACCIDENT SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc.

URINARY TRACT

Nephrectomy	$400.00
Nephroctomy, nephropexy, ureterotomy	$250.00
Cystoscopy for diagnosis only	$100.00
Operation for repair of urethra	$ 50.00

SPINE

Fracture of any vertebrae requiring removal of a portion thereof (coccyx and process excepted)	$500.00
Fracture of any vertebral process requiring removal	$250.00
Removal of nucleus pulposus or intervertebral disc	$250.00
Bone graft or fusion operation	$200.00
Fracture of sacrum or coccyx requiring open operation or removal of coccyx	$ 75.00

EXTREMITIES-UPPER

Amputation:	
At shoulder joint or resection of shoulder	$325.00
Of arm or forearm at or above wrist or resection of elbow or wrist	$200.00
Of entire finger or any part of hand	$ 50.00
Of part of finger (one or two phalanges)	$ 50.00
Fractures, Reduction:	
Of bones of arm or forearm	$150.00
Of any of the bones of wrist, hand or fingers	$ 50.00
Dislocation:	
Reduction of dislocation of shoulder or elbow joint	$ 50.00

EXTREMITIES-LOWER

Amputation:	
At hip joint	$500.00
Of thigh or leg at or above ankle – resection of knee or ankle joint	$250.00
Of any part of foot or complete toe	$ 50.00
Of any part of toe	$ 50.00
Fractures, Reduction:	
Of femur or pelvic bones, removal of semi-lunar cartilage	$150.00
Of bone or bones of leg	$125.00
Of any of the bones of tarsus or patella	$ 75.00
Of any other bones of foot	$ 50.00
Dislocations:	
Reduction of dislocation of hip or knee joint	$ 50.00

The amounts shown for fractures in Extremities–Upper and Lower are for simple fracture. For fractures requiring open reduction the maximum will be one and one-half times the amount for the corresponding simple fracture. For a fracture requiring an operation with bone grafting or metallic fixation at point of fracture, the maximum will be twice the amount for the corresponding simple fracture.

OSTEOMYELITIS

Osteomyelitis requiring:	
Cutting operation for removal of bone other than simple curettement of infected area, bones of skull, spine, pelvis, femur, leg, humerus, forearm	$125.00
Bones of tarsus, carpus, hand or foot	$ 50.00
Simple incision including curettement of bones for bone infection	$ 50.00

MISCELLANEOUS

Suturing surface wound	$ 25.00
Blood transfusion--plasma	$ 50.00
Incision for drainage of superficial infections	$ 25.00

HEAD

Cutting into cranial cavity	$325.00
Reduction of fracture of maxilla (upper or lower)	$ 50.00
requiring wiring of teeth or bone	$125.00

EYES

Operation for detached retina	$325.00
Removal or evisceration of both eyes	$325.00
Removal or evisceration of one eye	$150.00
Removal of foreign body from eye or eyelid	$ 25.00

NOSE

Reduction of fracture of nasal bones	$ 50.00

NECK

Tracheotomy	$ 75.00

CHEST

Complete pneumonectomy, lobectomy	$325.00
Bronchoscopy	$100.00
Aspiration--artificial pneumothorax	$ 50.00
Reduction of fracture of one or more ribs	$ 50.00

ABDOMEN

Gastrectomy, entero-enterostomy, splenectomy	$250.00
Intestinal resection	$250.00
Colostomy, closure of perforations	$250.00
Laparotomy	$250.00
Repair of hernia, single	$150.00
double	$250.00
Gastroscopy	$ 75.00
Paracentesis of abdomen	$ 50.00

THIS IS A SICKNESS ONLY RIDER AND IT DOES NOT PAY BENEFITS FOR LOSS FROM ACCIDENTS

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In this Rider, the person named as the Insured in the Policy Schedule will be referred to as "you," "your" or "the Insured."

The person named as the spouse in the Application will be referred to as "Covered Spouse".

SICKNESS TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT FOR SICKNESS

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) Sickness causes Total Disability which continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under a Physician's Regular and Personal Care for Sickness; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Sickness Rider Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care for Sickness continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one period of sickness.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Rider was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy and Rider.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if Sickness results in you or your Covered Spouse being confined in a Hospital as a resident patient under a Physician's Regular and Personal Care for Sickness. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for such Total Disability ends.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods:

(a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you or your Covered Spouse have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

DEFINITIONS

REGULAR AND PERSONAL CARE FOR SICKNESS means a planned program of observation and treatment requiring personal attendance by a Physician. Once started, this program must be continued under the existing standards of medical practice for treatment of the sickness.

SICKNESS RIDER DATE means the date this Sickness Rider is effective. This date is shown on the Policy Schedule.

SICKNESS means sickness or disease first manifesting itself: (1) more than 30 days after the Sickness Rider Date; and (2) while this Rider is in force. Sickness which manifests itself within 30 days of the Sickness Rider Date will be covered after two years in accordance with Part (b) of the Time Limit On Certain Defenses provision.

PRE-EXISTING CONDITION LIMITATION

This Rider will not cover a loss that: (1) starts within two years after the Sickness Rider Date; and (2) is caused by a Pre-existing Condition.

"Pre-Existing Condition" means a condition misrepresented or not revealed in the application and for which: (1) symptoms existed within a five year period preceding the Sickness Rider Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) medical advice or treatment was received from or recommended by a Physician within a five year period preceding the Sickness Rider Date.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: (a) After this Rider has been in force for two years, misstatements in the Application, unless fraudulent, will not be used to: (1) void the Rider; or (2) deny a claim for loss incurred or disability that starts after the two-year period.

(b) No loss that starts more than two years after the Sickness Rider Date will be reduced or denied on the grounds that a disease or physical condition has existed before the Sickness Rider Date.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement. If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Sickness beginning 10 days after the date of reinstatement, subject to any provisions noted on or attached to the reinstated Rider.

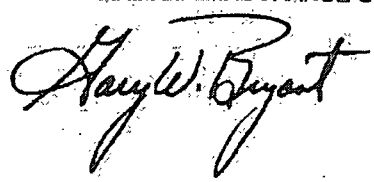
Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Sickness Rider Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.



Secretary



President

PENNSYLVANIA LIFE INSURANCE

Home Office: Lemoyne, Pennsylvania
Executive Office: 1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
Phone: (800) 275-7366

ADDITIONAL SURGICAL RIDER FOR SICKNESS

This Rider is made a part of the Policy to which it is attached and the Accident Surgical Indemnity Rider. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

SURGICAL INDEMNITY BENEFIT

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is also covered under the Policy's Accident Surgical Indemnity Rider.
2. The Covered Family Member is a resident patient in a Hospital; and
3. The Hospital stay is for a covered Sickness; and
4. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity. If a covered surgical procedure is performed on a Covered Family Member who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one sickness or any one accident.

ADDITIONAL DEFINITIONS

REGULAR AND PERSONAL CARE FOR SICKNESS means a planned program of observation and treatment requiring personal attendance by a Physician. Once started, this program must be continued under the existing standards of medical practice for treatment of the sickness.

SICKNESS means sickness or disease first manifesting itself: (1) more than 30 days after the Sickness Rider Date, and (2) while this Rider is in force. Sickness which manifests itself within 30 days of the Sickness Rider Date will be covered after two years in accordance with Part (b) of the Time Limit On Certain Defenses provision.

SICKNESS RIDER DATE means the date this Sickness Rider is effective. This date is shown on the Policy Schedule.

PRE-EXISTING CONDITION LIMITATION

This Rider will not cover a loss that: (1) starts within two years after the Sickness Rider Date; and (2) is caused by a Pre-existing Condition.

"Pre-Existing Condition" means a condition misrepresented or not revealed in the application and for which: (1) symptoms existed within a five year period preceding the Sickness Rider Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) medical advice or treatment was received from or recommended by a Physician within a five year period preceding the Sickness Rider Date.

ELIGIBILITY AND TERMINATION

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy.

NEWBORN CHILDREN: While this Rider is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decress of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of the birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to covered surgical procedures for: (1) Sickness; (2) medically diagnosed congenital defects or anomalies; (3) birth abnormalities; or (4) prematurity. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: (a) After this Rider has been in force for two years, misstatements in the Application, unless fraudulent, will not be used to: (1) void the Rider; or (2) deny a claim for loss incurred or disability that starts after the two-year period.

(b) No loss that starts more than two years after the Sickness Rider Date will be reduced or denied on the grounds that a disease or physical condition has existed before the Sickness Rider Date.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement. If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Sickness beginning 10 days after the date of reinstatement, subject to any provisions noted on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Sickness Rider Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

Secretary

President

ADDITIONS TO SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified, etc.

URINARY TRACT
Cystoscopy–operative procedure for removal of stone or tumor $150.00
SPINE
Radical operation for pilonidal cyst ..... $ 50.00
TUMORS
Cutting operation for removal of:
Malignant tumors except those of face, lip or skin $325.00
Malignant tumors of face, lip or skin ..... $ 75.00
Benign tumors ..... $ 50.00
Superficial tumors such as sebaceous cysts, fibromata lipoma, ganglia, enlarged lymph glands ..... $ 50.00
Removal of tissue for biopsy ..... $ 25.00
MISCELLANEOUS
Removal of nerve of ganglion for fifth nerve tic $250.00
Varicose veins, cutting ..... $ 75.00
injections ..... $ 50.00
Cutting operation for boils and carbuncles ..... $ 25.00
Felons or superficial abscess ..... $ 25.00
Excision of surface ulcers ..... $ 25.00
Operation for stretching of nerve ..... $ 50.00
HEAD
Removal of brain tumor or drainage of brain abscess $500.00
Trephining (skull) $250.00
EYES
Cataract Extraction with IOL (intra–ocular lens) $335.00
Extraction of cataract $250.00
Operation on external muscles of eye, sclerotomy, iridectomy $100.00
Removal of chalazion, pterygium or foreign body from eye or eyelid ..... $ 25.00
EAR
Fenestration $400.00
Mastoidectomy––single $200.00
double $250.00
Removal of polypus ..... $ 50.00
Paracentesis or myringotomy ..... $ 25.00
NOSE
Submucous resection $100.00
Radical operation on sinuses $150.00
Maxillary sinus puncture for drainage ..... $ 50.00
Removal of nasal polypus ..... $ 25.00
THROAT
Excision of larynx––esophagostomy $250.00
Tonsillectomy and (or) adenoidectomy ..... $ 75.00
Incision of peritonsillar abscess ..... $ 25.00
NECK
Thyroidectomy $250.00
CHEST
Coronary Artery Bypass $500.00
Thoracoplasty $325.00
Breast – radical operation, one $150.00
both $325.00
Empyema – lung abscess requiring rib resection, phrenic nerve crushing or excision $200.00
Bronchoscopy $100.00
Removal of benign tumor or tumors from breast ..... $ 75.00
ABDOMEN
Gastro–enterostomy, cholecystectomy, cholecystotomy $250.00
Intestinal resection $250.00
abscess, closure of perforated gastric or duodenal ulcer, operations requiring opening of bile ducts $250.00
PELVIS
Cutting into abdominal or pelvic cavity for diagnosis or treatment including hysterectomy, myomectomy of uterus, oophorectomy, salpingectomy, uterine fixation or removal of ovarian or broad ligament cysts $250.00
Repair of recto–vaginal or vesica–vaginal fistula $150.00
Operations on uterus and its appendages without abdominal approach; rectocele, cystocele $125.00
Dilation and curettage, including removal of polypi or cysts from cervix ..... $ 75.00
RECTUM
Proctectomy, prolapse of rectum $250.00
Radical operation for internal hemorrhoids, fistula in ano or stricture, including perirectal abscess ..... $ 75.00
Excision of fissure ..... $ 50.00
Operation for cure of external or mucocutaneous hemorrhoids ..... $ 50.00
MALE GENITAL ORGANS
Prostatectomy (including preliminary drainage of bladder) by open operation $250.00
Prostatectomy by trans–urethral resection $150.00
Radical operation for hydrocele, varicocele, undescended testicle, orchidectomy $100.00
Paracentesis of scrotum ..... $ 25.00

PLIC 0083

ROA 619

PENNSYLVANIA LIFE INSURANCE

Home Office: Lemoyne, Pennsylvania
Executive Office: 1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
Phone: (800) 275-7366

ACCIDENT EMERGENCY TREATMENT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

EMERGENCY TREATMENT BENEFIT

If Injury results in a Covered Family Member receiving Emergency Treatment in a Hospital Emergency Room, we will pay two times the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will only pay this benefit once for a Covered Family Member for any one Injury.

If Injury results in a Covered Family Member receiving Emergency Treatment in an Acute Care Facility, we will pay the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will pay this benefit once for a Covered Family Member for any one Injury. Treatment in an Acute Care Facility is subject to a maximum of two emergency visits per calendar year for each Covered Family Member.

X-RAY BENEFIT: If the Emergency Treatment for a covered Injury includes X-rays required by a Physician, we will pay an X-Ray Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will only pay this benefit once for a Covered Family Member for any one Injury.

CAST, SPLINT OR CRUTCHES BENEFIT: If the Covered Family Member receiving Emergency Treatment requires a cast, splint or crutches as the result of a covered Injury, we will pay a Cast, Splint or Crutches Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will pay this benefit only once, for only one of these requirements, for any one Injury. Such cast, splint or crutches must be recommended by a Physician and thereafter applied in the Hospital Emergency Room or Acute Care Facility.

AMBULANCE BENEFIT: If as a result of a covered Injury, a Covered Family Member requires transportation in an ambulance to or from a Hospital, we will pay an Ambulance Benefit equal to two times the Emergency Treatment Benefit amount shown in the Policy Schedule, for up to two trips for any one Injury.

DEFINITIONS

ACUTE CARE FACILITY means a facility providing care to patients who are not medically stable and who require frequent monitoring by health care professionals. This does not include the office of a private Physician.

ANY ONE INJURY when used in this Rider means losses incurred or medical treatment required arising out of the same accident.

CAST/SPLINT means a temporary device used to prevent motion of a joint or of the end of a fractured or broken bone. A cast/splint does not mean a brace.

CRUTCH means a support used under the armpits as an aid in walking. A crutch does not mean a cane, walker, wheelchair or other mobility device.

EMERGENCY TREATMENT means medical care for a covered Injury provided by a Physician within 72 hours of the time of the accident.

HOSPITAL EMERGENCY ROOM means a duly accredited facility set aside as such in a Hospital.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Rider effective date, only fraudulent misstatements made by you in the application for this Rider shall be used to void the Rider or to deny a claim for loss incurred commencing after the expiration of such two-year period.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement. If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Injury sustained after the date of reinstatement, subject to any provisions endorsed on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

Secretary

President

PR- 1946 Ed. 11.96

PLIC 0085

PENNSYLVANIA LIFE INSURANCE

Home Office: Lemoyne, Pennsylvania
Executive Office: 1001 Heathrow Park Lane
Suite 5001
Lake Mary, FL 32746
Phone: (800) 275-7366

RETURN OF PREMIUM RIDER

THIS IS A LIMITED RIDER. READ IT CAREFULLY.

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of the application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

RETURN OF PREMIUM BENEFIT

The Maturity Value is calculated on the Expiration Date. This amount will be payable to the primary insured at that time.

ADDITIONAL PROVISIONS

Any premiums waived after the effective date of this Rider in accordance with the Waiver of Premium provisions of the Covered Plans shall be considered as: (1) premiums paid when determining the total premiums paid for the Covered Plans; and (2) as a benefit paid when determining the total benefits paid under the Covered Plans.

Surrender of this Rider will be required as a condition to the payment of its Maturity Value or Death Benefit. If benefits accrue under the Covered Plans for claims incurred during the time this Rider was in force but after the Maturity Value has been paid, then such benefits shall be payable only to the extent that they exceed the amount of the Maturity Value or Death Benefit paid.

TERMINATION

This Rider will terminate on the Expiration Date or earlier if the benefits paid under the Covered Plans exceed the total of all premiums payable under this Rider and the Covered Plans from the Rider Effective Date to the Rider Expiration Date.

DEFINITIONS

Covered Plans: The policy to which this Rider is attached and all attached riders in force at the Effective Date of this Rider and those riders added within two years of the Effective Date of this Rider.

Expiration Date: 20 years from the Effective Date of this Rider.

Maturity Value: The total of all premiums paid during the life of this Rider on all Covered Plans plus the premium paid for this Rider less the total of all benefits paid on the Covered Plans.

We, Our, Us or The Company: Pennsylvania Life Insurance Company.

PR-301 SC Ed. 3-97

OTHER COVERAGE IN THIS COMPANY

The paragraph entitled "Other Coverage in This Company" contained in the Policy to which this Rider is attached is hereby deleted.

Other than stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.



Secretary

PR-301 SC Ed. 3-97

PLIC 0087

0809-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 2

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC 29172

IMPORTANT 8090

1. Print Clearly & answer all questions
2. If you need additional room to complete a question, attach a sheet of paper.
3. SIGN BOTTOM OF FORM

AUGUST 14, 2008

CLAIMANT'S NAME: Michael C. Russell Soc.Sec.Num: [redacted]

Date of Birth: [redacted] Home Phone: 803-955-0329 Work Phone: 803-513-0575

Are you receiving or applying for Worker's Compensation, Unemployment Compensation or other Disability benefits? YES____ NO ✓ ? If YES, please provide the name and address of the company(ies) and the policy number(s).

Employer Name: MCR Construction/LLC Employer Address: 1469 Dogwood Rd. West Columbia, SC 29172

Occupation: Owner of Company - Construction Monthly Gross Earnings: $ 4300

Job Duties: Owner, Vinyl Siding application

Were you working before you became disabled? YES ✓ NO____ If NO, what were you doing?

If you are self-employed, is your business still operating? YES ✓ NO____ If NO, when did it stop?

When did you first receive medical treatment? 6-18-08 Where? Lexington Medical Center

What is the name and address of the doctor treating you? Dr Taguinto 3 Medical Park Columbia, SC 29203

What is the name and address of any other doctors you have been referred to?

What is the name and address of your primary/family physician? Dr. Nagel 5535 Platt Springs Rd. Lexington, SC 29073

If you were in the hospital, please give dates of confinement: Admitted 6-18-08 Discharged 7-1-08

Hospital Lexington Medical Center Address 2720 Sunset Blvd. West Columbia, SC 29169
Palmetto Health Richland 5 Richland Medical Park Columbia, SC 29203
*(Include copy of hospital bill with this form)

Describe the sickness or injury Compound leg fracture, broken hip

If this is for a sickness condition, when did it first begin?

If this is an accident, when and where did it happen? Date: 6-18-08 Time: 9:20 PM Place: I-26 Exit 115

Describe how it happened. Motorcycle accident

IF THIS IS A MOTOR VEHICLE ACCIDENT, PLEASE INCLUDE A COPY OF THE POLICE REPORT.

Have you ever had a similar condition in the past? YES____ NO ✓ If YES, please give dates, a brief description and the name and address of the doctor who treated you.

IF EMPLOYED, did the condition above cause you to lose any time from work? YES ✓ NO____ If YES, provide dates.

First Day not worked 6-19-08 What duties were you unable to do? all

When were you able to do SOME of your duties? Date:_____ ALL of your duties? Date:_____

IF RETIRED, A HOUSEWIFE, STUDENT OR UNEMPLOYED, did the above condition prevent you from doing your normal daily activities? YES____ NO____ If YES, provide dates. First Day unable to do activities

What activities were you unable to do?

When were you able to do SOME of your normal activities?

When were you able to do ALL of your normal activities?

Did this condition cause you to be confined? YES____ NO ✓ If YES, provide dates. FROM_____ TO_____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Pennsylvania Life Insurance Company - PO Box 12355, Pensacola, FL 32591-2355
CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE - any medical professional, medical care institution, consumer reporting agency insurance institution, insurance support organization, institution source, governmental agency including, but not limited to, the Social Security Administration and the Veterans Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, it's officers, employees, agency or legal representative, and, any insurance support organization and consumer reporting agency acting on The Company's behalf; with any and all medical records and personal information, requested about me or any of my minor children.

I UNDERSTAND that this Authorization will be used to obtain information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use OT drugs or alcohol. I UNDERSTAND the information obtained by the use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy. I KNOW that I or my legal representative may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I UNDERSTAND that the duration of the Authorization is for. The term of coverage of the policy under which a claim for benefits has been submitted. If this Authorization is given in connection with a claim for disability or life insurance benefits, I UNDERSTAND that is valid for the duration of the claim.

Michael Russell 8-27-08
SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE

1052C

DEFENDANT'S EXHIBIT 2

PLIC 0370

Attending Physician's Report

PATIENT'S NAME: Michael Russell DOB:

1. DIAGNOSIS: (Please provide ICD Code) Primary 808.0 Secondary 883.30

2. Describe any other disease or infirmity affecting the present condition.	
3. When did symptoms first appear or accident happen?	DATE: 6.18.08
4. If accident, please describe.	motorcycle accident
5. When did this patient first consult you for this condition?	DATE: 6.18.08 TIME ____ AM ____ PM
6. Has patient ever had same or similar conditions? If YES, please state when and describe	Yes ____ No ✓
7. Please provide the name(s) and address(es) of any other treating physician(s)	
8. Provide the CPT code and date of any surgeries performed.	CPT CODE: 27759 DATE: 6.24.08 CPT CODE: 27226 DATE: 6.24.08
9. a. If hospitalized, give name and address of hospital & admission & discharge dates.	Hospital: Palmetto Richland Memorial Address: 5 Medical Pk. Dr. City: Columbia State: SC Admitted: 6.20.08 Discharged: 7.1.08
b. If confined to a nursing facility, give name and address of the facility and admission and discharge dates.	Nursing Facility: ____ Address: ____ City: ____ State: ____ Admitted: ____ Discharged: ____
10. Provide dates of treatment:	Office: 7/15/08, 8/11/08 Hospital: 6.20.08 - 7.01.08 Nursing Facility: ____
11. Is patient still under your care for this condition? If NO, give the date discharged from your care.	YES ✓ NO ____ DATE: ____
12. How long was (or will) the patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	FROM: WJ date TO: undetermined
13. How long was (or will) the patient (be) partially disabled (able to perform some but not all of his/her occupational duties)?	FROM: ____ TO: same as above
14. If retired, housewife, student or other non-employed, please indicate a reasonable period of recovery.	No activities FROM: ____ TO: ____ Partial activities FROM: ____ TO: ____
15. Was house confinement necessary? If YES, give dates. (see definition of "confinement" below)	YES: ____ NO: ✓ FROM ____ TO: ____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

REMARKS

Name of Physician: (please print)
John Taquinto
Address: 3 Med. Plc. Dr, Ste. 330
City: Columbia
State: SC Zip: 29203

Signature: [signature]
Date: 6/27/08 Tax ID #: 582296053
Telephone #: 803.434.6958
Fax #: 803.434.8537

THANK YOU - Your time is appreciated
Pennsylvania Life Insurance Company P. O. Box 12355, Pensacola, FL 32591-2355

1052C

PLIC 0371

Mail FR-10 to: SC Department of Motor Vehicles
Office of Financial Responsibility (803) 896-5000
PO Box 1498, Blythewood, SC 29016

South Carolina Department of Motor Vehicles (DMV)
FR-10 (REV. 10/05)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company Representatives can submit your insurance information at WWW.SCALIR.COM

Date	Time	County	Collision Location (Rt. # / Name)	Miles:	Dir.	In Near City or Town of:
8-7-24	2124	1- Interstate 4- Secondary 2- US Primary 5- County 3- SC Primary	5 26	N/A	N E S W	Cayce

To Vehicle Owner/ Operator: **Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.**

FR10 Audit No. X-561055

Driver/Pedestrian's Full Name: Russell - Michael

Unit # 1 | Sex: M | Race: W | Street: 1169 Rimwood Rd
Birth Date: [redacted] | City, State, & Zip: West Columbia SC 29172
State: SC | Driver's License #: [redacted] | Insurance Company:
Year: 23 | Body: PKT | Vehicle Make: [illegible] | VIN #: [illegible]
State: SC | Year: 2024 | License Plate #: ZW0339 | Owner's D.L. #: [redacted]
Home Telephone: (843) 965-0329 | Owner's Full Name: Russell - Michael
Bus. Telephone: N/A | Street: 1169 Rimwood Rd
Contributed To Collision: Yes / No | City, State, & Zip: West Columbia SC 29172

FR10 Audit No. X-561056

Driver/Pedestrian's Full Name: Collins - Connie Lynn

Unit # 2 | Sex: F | Race: W | Street: 1104 Shorecrest Dr
Birth Date: [redacted] | City, State, & Zip: West Columbia SC 29172
State: SC | Driver's License #: [redacted] | Insurance Company: Travelers
Year: 2020 | Body: 4S | Vehicle Make: Hyun | VIN #: [illegible]
State: SC | Year: 2024 | License Plate #: SDJ784 | Owner's D.L. #: [redacted]
Home Telephone: ( ) | Owner's Full Name: Collins - Connie Lynn
Bus. Telephone: ( ) | Street: 1104 Shorecrest
Contributed To Collision: Yes / No | City, State, & Zip: West Columbia SC 29172

FR10 Audit No. X-561057

Driver/Pedestrian's Full Name:

Unit # | Sex | Race | Street
Birth Date | City, State, & Zip
State | Driver's License # | Insurance Company:
Year | Body | Vehicle Make | VIN #
State | Year | License Plate # | Owner's D.L. #
Home Telephone | Owner's Full Name
Bus. Telephone | Street
Contributed To Collision: Yes / No | City, State, & Zip

All Units Insurance Information
(to be completed by Investigating Office)

Automobile liability insurance information for Unit #
Company Name: Travelers | Area Code/Phone Number: (800) 842-3675
Agency Name: ON 1943 | Policy Number: [redacted]

Automobile liability insurance information for Unit #
Company Name: | Area Code/Phone Number: ( )
Agency Name: | Policy Number:

Automobile liability insurance information for Unit #
Company Name: | Area Code/Phone Number: ( )
Agency Name: | Policy Number:

Automobile Liability Insurance Information

Notice of Requirement Accepted | Signature | Y: N: Refused to Affix Signature? | Y: N: Vehicle Subject to Registration in SC?

(To Be Completed Below on Entered at WWW.SCALIR.COM By Insurance Company Representative. This information may be mailed to DMV in manner in which this form was submitted electronically.)

Reference to Unit #: I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below stated insurance company on the date of the collision.

Insurance Company | Policy #: | Signature | Title
Beginning Date: | Ending Date: | Policy Holder: | NAIC # (Assigned by S.C. Dept. of Ins.) | Bus. Telephone

Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, disregard the above portion.

Form FR-10 Not Issued: Section 56-10-520

- Check here if a Form SR-22 Fleet Policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle.
- Check here if a certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate number: SI-
- Check here if liability insurance was not in effect to comply with South Carolina statutory requirements.

No. FR-10 Issued to Operator/ Owner of Unit #:
Summons Issued to:
For operating or allowing the operation of an uninsured vehicle | Summons Number: | Signature | Date

Investigating Officer's Name: [illegible] | Rank: Trp | Badge #: 7240 | Code: | Date: 8-10-24
Reviewer's Name | Rank | Internal Agency Code

PLIC 0369

811

00

FedEx. US Airbill Express

FedEx Tracking Number 8626 5812 4712

1 From This portion can be removed for Recipient's records.

Date 9/3/08 FedEx Tracking Number 8626581247 12

Sender's Name NIKE BARD Susanne Bucwell Phone 803 252-0606

Company BARB, SNYDER & CO

Address 1751 SAINT JULIAN PL Dept/Floor/Suite/Room

City COLUMBIA State SC ZIP 29204-2408

2 Your Internal Billing Reference

3 To

Recipient's Name Phone 800 275-7366

Company Pennsylvania Life Insurance Company

Recipient's Address 411 Baylen Street Dept/Floor/Suite/Room

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Third business day.** Saturday Delivery NOT available.

* To most locations.

** To most locations.

5 Packaging

FedEx Envelope* FedEx Pak* Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak. FedEx Box FedEx Tube Other

* Declared value limit $500.

6 Special Handling Include FedEx address in Section 3.

SATURDAY Delivery Not available for FedEx Standard Overnight, FedEx First Overnight, FedEx Express Saver, or FedEx 3Day Freight.

HOLD Weekday at FedEx Location Not available for FedEx First Overnight.

HOLD Saturday at FedEx Location Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

Does this shipment contain dangerous goods? One box must be checked.

No Yes As per attached Shipper's Declaration Yes Shipper's Declaration not required

Dry Ice Dry Ice, 9, UN 1845 x kg

Cargo Aircraft Only

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging.

7 Payment Bill to: Enter FedEx Acct. No. or Credit Card No. below.

Sender Acct. No. in Section 1 will be billed. Recipient Third Party Credit Card Cash/Check

Obtain Recipient Acct. No.

Total Packages Total Weight Credit Card Auth.

†Our liability is limited to $100 unless you declare a higher value. See the current FedEx Service Guide for details.

8 Residential Delivery Signature Options If you require a signature, check Direct or Indirect.

No Signature Required Package may be left without obtaining a signature for delivery.

Direct Signature Someone at recipient's address may sign for delivery. Fee applies.

Indirect Signature If no one is available at recipient's address, someone at a neighboring address may sign for delivery. Fee applies.

519

Rev. Date 10/06 Part #152210-2005 ©1994-2006 FedEx PRINTED IN U.S.A. SRS

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W. COLA, SC 29072

Check: 215 Table: 984 #Party: 1
Server: PM BAR PM BAR 20:01

BUD LITE BOTTLE	2.75
CROWN ROYAL	5.50
SOUTHERN COMFORT	4.75
CROWN ROYAL	5.50
Jager	5.50
Jager	5.50
CROWN ROYAL	5.50
Sub Total:	35.00
Tax 1:	2.45
Tax 2:	1.61
20:40 Total:	39.06

Payments:	Amt-Tend	Tip/Chg	Tally
VISA	59.06	20.00	39.06
06/18/2008 20:57			39.06
Memo: 018148 [redacted] 11/04,			39.06

Cashier: PM BAR PM BAR

DEFENDANT'S EXHIBIT 3

Russell 0104

STATE OF SOUTH CAROLINA)) COUNTY OF LEXINGTON)	IN THE COURT OF COMMON PLEAS FOR THE FIFTH JUDICIAL CIRCUIT
Mike Russell, Plaintiff, v. Randolph Gill and Pennsylvania Life Insurance Company, Defendants.	C.A. No.: 2011-CP-32-4981 **AFFIDAVIT OF MIKE RUSSELL**

PERSONALLY appeared before me Mike Russell who, upon first being duly sworn, states as follows:

1. I am over the age of eighteen (18) and otherwise qualified to give sworn testimony.
2. I am the Plaintiff in this action.
3. In 1999, I was self employed in construction.
4. In 1999, an insurance salesman came to our job site offering to sell me disability insurance.
5. That night, my wife and I discussed whether or not I should get disability insurance since I had never had it before.
6. I decided to purchase disability insurance to protect my family in case I had an accident and could not work.
7. I signed an application in 1999 to purchase disability insurance. I was not told that there was an alcohol exclusion. If I had known of an alcohol exclusion, I would not have purchased the policy. There were no written documents given to me that stated that there

DEFENDANT'S EXHIBIT 4

EXHIBIT B

was an alcohol exclusion. The agent did not tell me that there was an alcohol exclusion. The agent did not point out to me in the written application any words that would have told me that there was an alcohol exclusion.

8. I began paying my premiums for my disability insurance in 1999. My disability insurance was to pay me $2,000 per month if I became disabled.

9. I did not receive a copy of my disability insurance policy from the company. The only documents I received are the documents attached as Exhibit 1.

10. I did not ask for a copy of the policy or know that what I had received was not the policy. I continued to believe that what I had received as Exhibit 1 was the policy.

11. I continued to have the premiums deducted from my bank account. I was never late with my payments for my disability insurance.

12. In 2002, I decided to increase my disability coverage and purchased a new policy providing an additional $500 per month for a total coverage of both policies of $2,500 per month.

13. I completed the application on June 27, 2002. My application is attached as Exhibit 2.

14. Again, I did not receive a copy of the policy. The documents I received as Exhibit 2 were the only documents I received from my agent.

15. I have since been shown a printed page that shows an alcohol exemption in the jacket of a folder from Pennsylvania Life that included my application. I would not have purchased a policy with an alcohol exemption had I known about it. I did not know there was an alcohol exemption.

16. I was severely injured in a motorcycle accident in August 2008. I suffered injuries to my

pelvis and leg. My hip has been replaced and I have metal rods leading from my knee to my ankle. I am in constant pain.

17. My accident was very severe and my wife came to the hospital to help care for me. I was hospitalized for an extended period of time. I also received surgeries on my hip and leg.

18. My wife called Pennsylvania Life to report my accident after I was out of danger. My wife was told that we could not make a claim, because she had not notified them within seven (7) days of the accident.

19. Eventually, Pennsylvania Life allowed me to make a claim and found me to be disabled. Pennsylvania Life began paying me my monthly disability benefits.

20. My wife requested a copy of my policy in August 2008 when she first contacted them. Pennsylvania Life has never sent me a copy of my policy. The only documents I have received are those in Exhibits 1 and 2.

21. Pennsylvania Life began paying me disability benefits after the wreck and has continued to do so since 2008.

22. Pennsylvania Life has continued to draft my bank account for premiums for my disability insurance even though I have been disabled. I understood that I would not be required to pay premiums six months after I began receiving benefits. It was my understanding that Pennsylvania Life should not be deducting these premiums from my bank account.

23. I have not received each of the disability checks quickly. There have been times that it has been more than thirty (30) days between checks, making it hard for my family to pay its bills and budget. On at least one occasion there was 100 days between the checks.

24. When I have received a check, my wife has deposited the check in the bank the following

day. Attached to each check is a certificate that my doctor must fill out and be sent back to Pennsylvania Life each month before Pennsylvania Life will issue the next monthly check. Someone must take the certificate to the doctor's office, go back and pick it up, and mail it to Pennsylvania Life immediately.

25. I understood that if I didn't make a claim on this policy that after 20 years I would receive a return on what I had paid.

26. I also have a cancer policy with Pennsylvania Life. I would like to cancel the policy, but am afraid that Pennsylvania Life will cancel my disability policy and stop my benefits instead.

27. I applied for, but was denied Social Security benefits. I did not appeal that decision, because I understood that Social Security regularly denies benefits and appeals are a long and difficult process.

28. Pennsylvania Life has filed a Motion and attached a copy of a document they claim to be my policy.

29. I have never seen this document before. It has never been mailed or delivered to me.

30. I have never agreed to the terms of this document. This is not my 1999 policy. This is not my 2002 policy. I can't tell what it is, because there is a declarations sheet that has 2002 dates.

31. I have never canceled my original 1999 policy.

32. In the wreck, I was hit by a car that pulled out ahead of me. I had no way of avoiding the accident.

33. I was charged with DUI after the wreck.

34. I was found not guilty of that charge.

35. I had three (3) drinks over four (4) hours prior to the wreck.

36. I was given a substance by medical personnel after the accident that, I believe, may have impacted the alcohol level results in my tests.

37. I am an experienced motorcycle driver and am able to handle and maneuver a motorcycle well in all types of traffic.

38. To my knowledge, my insurance policy has never been provided to my attorney in discovery or at any other time prior to the Motion Pennsylvania Life has filed trying to get my case thrown out.

39. I believe Pennsylvania Life is trying to substitute this document to avoid paying me.

40. Pennsylvania Life has paid me since my accident.

41. In November 2009, Pennsylvania Life sent an individual to my home to evaluate me. It was my understanding that the individual was going to recommend a lump sum settlement to me. After that time, I believe, Pennsylvania Life began looking for a way to stop paying me benefits. Their payments stopped for approximately five (5) months. It was at this time that I acquired an attorney and filed suit. Since approximately November 2009, I have been unable to get any answers or communicate with anyone at Pennsylvania Life.

42. I purchased my disability policy in 1999 in good faith. I have paid my premiums on time.

43. I purchased an additional policy in 2002 to provide my family additional coverage.

44. In 2008, I was severely injured and disabled.

45. I could not avoid the accident.

46. Pennsylvania Life refused in 2008 and at any other time to provide me with a copy of my policy.

FURTHER AFFIANT SAYETH NOT.

Mike Russell
MIKE RUSSELL

SWORN TO AND SUBSCRIBED
before me this 31st day of October, 2012
[signature] (L.S.)
NOTARY PUBLIC FOR SOUTH CAROLINA
My Commission Expires: 6-5-2017

EXHIBIT 1

1 800 Ask Penn

Randy Gill

608 0600

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

ACCIDENT SICKNESS PROTECTION

PENNSYLVANIA LIFE INSURANCE CO.

ACCIDENT SICKNESS PROTECTION

If You Qualify

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

When disability prevents you from earning an income, you can continue to remain financially stable with an insurance plan to help meet your monthly obligations.

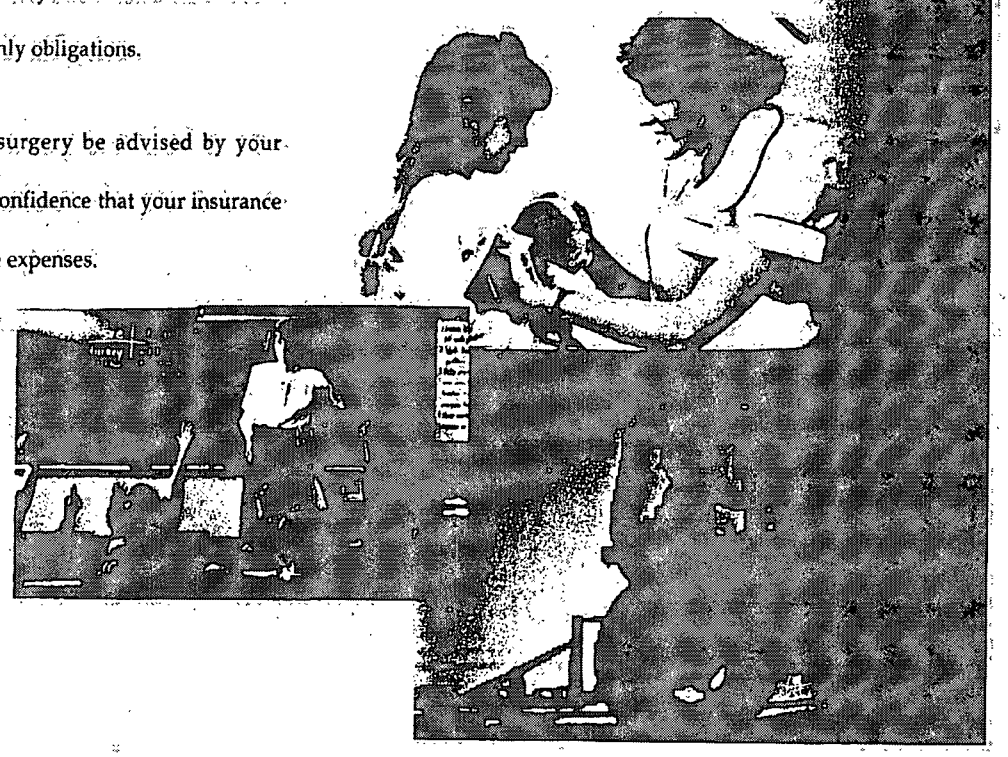
Should hospitalization or surgery be advised by your physician you can have the confidence that your insurance plan will help you meet these expenses.

Guaranteed Renewable

Coverage is guaranteed renewable in accordance wit your specific state requirements.

The Best Defense is a Good Offense

Put together a plan for protection when the unexpect happens. Choose the insurance benefits that will keep y and your family worry free during times of financial str



POLICY SCHEDULE

INSURED MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

POLICY NUMBER	[redacted]9360
POLICY DATE	11-19-99
FIRST RENEWAL DATE	12-19-99
ANNUAL PREMIUM	$1,501.97
MODE	MONTHLY PAC
MODE PREMIUM	$135.18

INITIAL ACCIDENT COVERAGE -- PRIMARY INSURED		EFFECTIVE DATE
MONTHLY TOTAL DISABILITY BENEFIT	$2,000.00*	11-19-99
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
MONTHLY TOTAL DISABILITY BENEFIT	$500.00*	07-19-02
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
ACCIDENTAL DEATH BENEFIT	$25,000.00	11-19-99
ACCIDENTAL DEATH BENEFIT	$75,000.00	07-19-02
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$1,000.00	11-19-99
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$4,000.00	07-19-02
EMERGENCY TREATMENT BENEFIT	$25.00	07-19-02
RETURN OF PREMIUM RIDER	YES	11-19-99

* TOTAL DISABILITY BENEFITS MAY END FOR TOTAL DISABILITY STARTING AFTER AGE 65 (SEE TOTAL DISABILITY RIDER)

1900

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) Injury causes Total Disability which starts within 30 days after the date of the accident and continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under the Regular and Personal Care of a Physician; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Policy Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care of a Physician continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one accident.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Policy was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if Injury results in you or your Covered Spouse being confined in a Hospital as a resident patient under the Regular and Personal Care of a Physician. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for Total Disability end.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods: (a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

/s/ Peter Keuser

Secretary

/s/ William E. Wehmer

President

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENTAL DEATH BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

If Injury results in the death of a Covered Family Member within 90 days of the accident, we will pay the Accidental Death Benefit shown in the Policy Schedule to the designated Beneficiary.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for death which results from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J Peter Kinser

Secretary

William E Wehner

President

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
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Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT SURGICAL INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is a resident patient in a Hospital; and
2. The Hospital stay is for a covered Injury; and
3. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Accident Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity, except that no amount is payable for dental treatment unless such treatment results from accidental bodily injury to natural teeth or gums. If a covered surgical procedure is performed on an Insured who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Accident Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one accident.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for covered surgical procedures resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser
Secretary

William E. Wehner
President

ACCIDENT SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc.

URINARY TRACT	
Nephrectomy	$400.00
Nephroctomy, nephropexy, ureterotomy	$250.00
Cystoscopy for diagnosis only	$100.00
Operation for repair of urethra	$ 50.00
SPINE	
Fracture of any vertebrae requiring removal of a portion thereof (coccyx and process excepted)	$500.00
Fracture of any vertebral process requiring removal	$250.00
Removal of nucleus pulposus or intervertebral disc	$250.00
Bone graft or fusion operation	$200.00
Fracture of sacrum or coccyx requiring open operation or removal of coccyx	$ 75.00
EXTREMITIES-UPPER	
Amputation:	
At shoulder joint or resection of shoulder	$325.00
Of arm or forearm at or above wrist or resection of elbow or wrist	$200.00
Of entire finger or any part of hand	$ 50.00
Of part of finger (one or two phalanges)	$ 50.00
Fractures, Reduction:	
Of bones of arm or forearm	$150.00
Of any of the bones of wrist, hand or fingers	$ 50.00
Dislocation:	
Reduction of dislocation of shoulder or elbow joint	$ 50.00
EXTREMITIES-LOWER	
Amputation:	
At hip joint	$500.00
Of thigh or leg at or above ankle – resection of knee or ankle joint	$250.00
Of any part of foot or complete toe	$ 50.00
Of any part of toe	$ 50.00
Fractures, Reduction:	
Of femur or pelvic bones, removal of semi-lunar cartilage	$150.00
Of bone or bones of leg	$125.00
Of any of the bones of tarsus or patella	$ 75.00
Of any other bones of foot	$ 50.00
Dislocations:	
Reduction of dislocation of hip or knee joint	$ 50.00

The amounts shown for fractures in Extremities–Upper [illegible] fracture. For fractures requiring [illegible] times the amount for the corresponding simple fracture. For a fracture requiring an operation with bone grafting or metallic fixation at point of fracture, the maximum will be twice the amount for the corresponding simple fracture.

OSTEOMYELITIS	
Osteomyelitis requiring:	
Cutting operation for removal of bone other than simple curettement of infected area, bones of skull, spine, pelvis, femur, leg, humerus, forearm	$125.00
Bones of tarsus, carpus, hand or foot	$ 50.00
Simple incision including curettement of bones for bone infection	$ 50.00
MISCELLANEOUS	
Suturing surface wound	$ 25.00
Blood transfusion--plasma	$ 50.00
Incision for drainage of superficial infections	$ 25.00
HEAD	
Cutting into cranial cavity	$325.00
Reduction of fracture of maxilla (upper or lower)	$ 50.00
requiring wiring of teeth or bone	$125.00
EYES	
Operation for detached retina	$325.00
Removal or evisceration of both eyes	$325.00
Removal or evisceration of one eye	$150.00
Removal or foreign body from eye or eyelid	$ 25.00
NOSE	
Reduction of fracture of nasal bones	$ 50.00
NECK	
Tracheotomy	$ 75.00
CHEST	
Complete pneumonectomy, lobectomy	$325.00
Bronchoscopy	$100.00
Aspiration--artificial pneumothorax	$ 50.00
Reduction of fracture of one or more ribs	$ 50.00
ABDOMEN	
Gastrectomy, entero-enterostomy, splenectomy	$250.00
Intestinal resection	$250.00
Colostomy, closure of perforations	$250.00
Laparotomy	$250.00
Repair of hernia, single	$150.00
double	$250.00
Gastroscopy	$ 75.00
[illegible]	$ 50.00

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
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ACCIDENT EMERGENCY TREATMENT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

EMERGENCY TREATMENT BENEFIT

If Injury results in a Covered Family Member receiving Emergency Treatment in a Hospital Emergency Room, we will pay two times the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will only pay this benefit once for a Covered Family Member for any one Injury.

If Injury results in a Covered Family Member receiving Emergency Treatment in an Acute Care Facility, we will pay the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will pay this benefit once for a Covered Family Member for any one Injury. Treatment in an Acute Care Facility is subject to a maximum of two emergency visits per calendar year for each Covered Family Member.

X-RAY BENEFIT: If the Emergency Treatment for a covered Injury includes X-rays required by a Physician, we will pay an X-Ray Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will only pay this benefit once for a Covered Family Member for any one Injury.

CAST, SPLINT OR CRUTCHES BENEFIT: If the Covered Family Member receiving Emergency Treatment requires a cast, splint or crutches as the result of a covered Injury, we will pay a Cast, Splint or Crutches Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will pay this benefit only once, for only one of these requirements, for any one Injury. Such cast, splint or crutches must be recommended by a Physician and thereafter applied in the Hospital Emergency Room or Acute Care Facility.

AMBULANCE BENEFIT: If as a result of a covered Injury, a Covered Family Member requires transportation in an ambulance to or from a Hospital, we will pay an Ambulance Benefit equal to two times the Emergency Treatment Benefit amount shown in the Policy Schedule, for up to two trips for any one Injury.

DEFINITIONS

ACUTE CARE FACILITY means a facility providing care to patients who are not medically stable and who require frequent monitoring by health care professionals. This does not include the office of a private Physician.

ANY ONE INJURY when used in this Rider means losses incurred or medical treatment required arising out of the same accident.

CAST/SPLINT means a temporary device used to prevent motion of a joint or of the end of a fractured or broken bone. A cast/splint does not mean a brace.

CRUTCH means a support used under the armpits as an aid in walking. A crutch does not mean a cane, walker, wheelchair or other mobility device.

EMERGENCY TREATMENT means medical care for a covered Injury provided by a Physician within 72 hours of the time of the accident.

HOSPITAL EMERGENCY ROOM means a duly accredited facility set aside as such in a Hospital.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Rider effective date, only fraudulent misstatements made by you in the application for this Rider shall be used to void the Rider or to deny a claim for loss incurred commencing after the expiration of such two-year period.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement.If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to injury sustained after the date of reinstatement, subject to any provisions endorsed on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser — Secretary

William E. Wehner — President

Benefit Options Available*

Accident Total Disability

Accident Total Disability Benefit is paid to you each month while you are Totally Disabled due to injury from the date the elimination period ends, if any, up to the maximum benefit period allowed. Total Disability must start within 30 days of the accident. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability ends.)

Accident Surgical Benefit

Benefits payable to you for Surgery as a result of an Injury. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Accident Hospital Benefit

Hospital Benefits paid to you from the first day you are hospitalized as a result of injury for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Accidental Death Benefit

Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an Injury within 90 days of the accident.

Waiver of Premium Benefit - Accident

Premium Waived If You Are Totally Disabled from an accident.
If you are totally disabled for six months or more as a result of an Injury, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

Sickness Total Disability

Sickness Total Disability Benefit is paid to you while you are Totally Disabled as a result of Sickness. Benefits payable from the date the elimination period ends up to the maximum benefit period allowed. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability due to Sickness ends.)

Sickness Surgical Benefit

Benefits payable to you for Surgery as a result of Sickness. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Sickness Hospital Benefits

Hospital benefits paid to you from the first day you are hospitalized as a result of Sickness for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Waiver of Premium Benefit - Sickness

Premium Waived If You Are Totally Disabled from sickness.
If you are totally disabled for six months or more as a result of Sickness, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

Inflation Protection

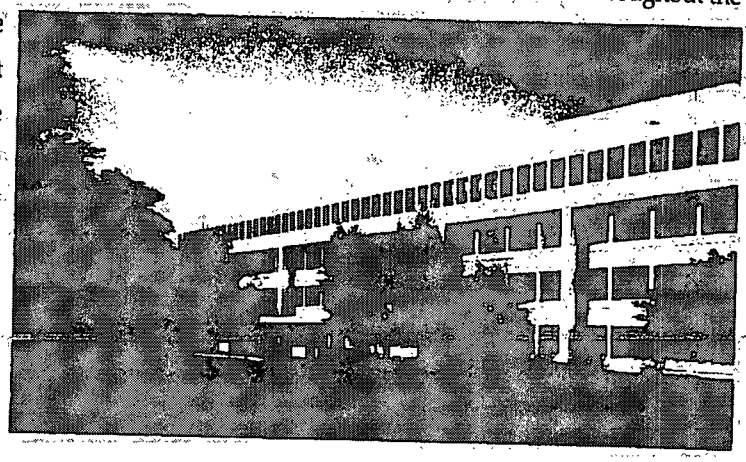
5% per year increase in benefits to 50% total increase after 10 yrs.

We will increase your daily benefit 5% per year for 10 years, if you have had continuous coverage. At the end of 10 years, your daily Injury and/or Sickness benefits are 150% of the original amount. The benefit for any claim will be fixed for its duration as of the date it starts.

**Benefit descriptions, definitions, exclusions and limitations may vary by state. Please refer to your policy/rider and the insert*

Safe, Solid, Stable

Pennsylvania Life Insurance Company is licensed to do business in 49 states, the District of Columbia and Canada. We underwrite, market and service a wide variety of insurance coverage including life, accident and health.



Our Policyholder First Philosophy

With more than a half million policyholders, Pennsylvania Life Insurance Company's US operations has made substantial investments in technology in order to create and upgrade the kind of system required to provide every customer with top quality, responsive service. Although we manage more than 2,600 claims each month and pay more than $4,500,000 in benefits every month, we're only as good as the satisfaction of the last customer.

The Personal Approach

Pennsylvania Life is not a small company. With over 100 offices throughout the United States and Canada, we are a substantial company. But we haven't grown to our current size by ignoring our customers or creating large, unresponsive bureaucracies and annoying paperwork.

Our highly trained insurance professionals have built their success on your satisfaction. You'll find their personal approach to service is a welcome change to the way most businesses operate. It also means that your insurance representative will build a program of adequate, customized coverage based on your needs, rather than an off-the-shelf product line.

We've been in business for over 100 years because we're an insurance company that has never lost sight of why we're in business... to provide our customers with the insurance coverage they need when they need it the most.

PENNSYLVANIA LIFE INSURANCE CO.
600 Courtland Street, Orlando, Florida 32804

PB-1900 A/S Rev. 10.98

CN 96-0102

EXHIBIT 2

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

ACCIDENT SICKNESS PROTECTION



PENNSYLVANIA LIFE INSURANCE CO.

ACCIDENT SICKNESS
PROTECTION

If You Qualify

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

When disability prevents you from earning an income, you can continue to remain financially stable with an insurance plan to help meet your monthly obligations.

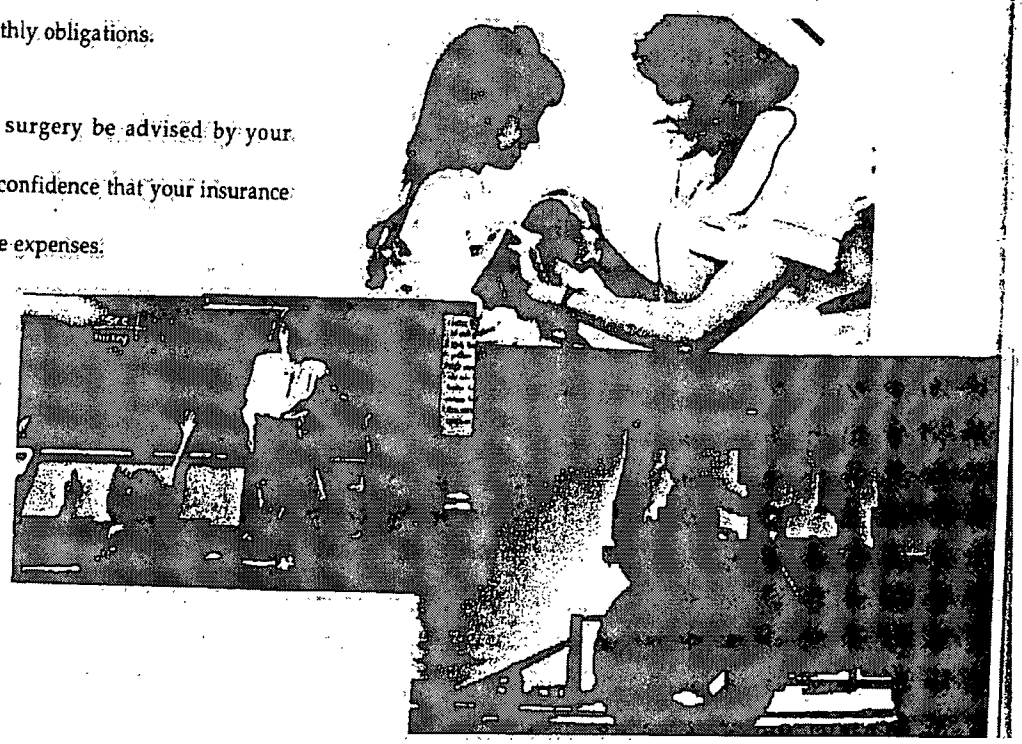
Should hospitalization or surgery be advised by your physician you can have the confidence that your insurance plan will help you meet these expenses.

Guaranteed Renewable

Coverage is guaranteed renewable in accordance with your specific state requirements.

The Best Defense is a Good Offense

Put together a plan for protection when the unexpected happens. Choose the insurance benefits that will keep you and your family worry free during times of financial stress.



ACCIDENT SICKNESS PROTECTION

If You Qualify

Which Program Best Fits Your Needs?

Accident Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	ADB Amount	Options IP	Options WP	Premium Total
		$ 500	7 days	Life yrs.	$	$400	$200	$7500			$35.32
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$

Incremental Cost: $

Paid $2 diff. 2 mo. Pr 6/27/97

Sickness Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	Options IP	Options WP	Premium Total
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$

Incremental Cost: $

$135.32 mo

Paid

Monthly Disability Benefit

Present Income	Disability Income Benefit
$4,000 per month	$2,000 per month
$3,600 per month	$1,800 per month
$3,000 per month	$1,500 per month
$2,400 per month	$1,200 per month
$2,000 per month	$1,000 per month
$1,600 per month	$800 per month
$1,200 per month	$600 per month
$800 per month	$400 per month
$400 per month	$200 per month

(Monthly benefit not to exceed 50% of present income)

PI 1900 A/S NC 12.96

CN 96-1577

ROA 651

Definitions, Exceptions and Limitations

INJURY means accidental bodily injury sustained directly and independently of disease or bodily infirmity, or any other cause while your coverage is in force.

SICKNESS means sickness or disease first manifesting itself more than 30 days after the issue date of the sickness rider and while your coverage is in force.

TOTAL DISABILITY means that you or your Covered Spouse are unable to engage in any employment or occupation for which you or your Covered Spouse are, or become, qualified by reason of education, training or experience.

TOTAL DISABILITY Coverage ends at age 65. However, if you are working full time your benefit will continue to age 70. When your Disability Benefit ends it will automatically convert to Hospital Confinement paid to you from the first day you are confined in a Hospital - even for life.

HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity, being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state – serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF _____ Date _____, _____ the sum of _____ Dollars _____ Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $ _____

LICENSED AGENT _____

AGENT LICENSE NUMBER _____

ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

JUL 09 2002

APPLICATION FOR INSURANCE

DATE (MMDDYYYY): 06 27 2002

MAIL PREMIUM NOTICES: BUSINESS ✓ RESIDENCE ✓

POLICY NO: [redacted] 9360

POLICYHOLDER: NEW CURRENT ✓

INSURED NAME

LAST: Russell SUFFIX: FIRST: Mike MI: SOCIAL SECURITY NUMBER: [redacted]

ADDRESS (Street/Rural Route): 1469 Dogwood Rd ADDRESS (Line 2): [redacted]

CITY: West Columbia STATE: SC ZIP CODE: 29172 COUNTY: Lexington

AREA CODE/ TELEPHONE: 8039550329 BEST TIME/ DAY TO CALL: eve

AGE: 29 BIRTHDATE (MMDDYYYY): [redacted] STATE OF BIRTH: IL SEX: M

HEIGHT (Ft. In.): 5 09 WEIGHT: 160 WEIGHT CHANGE LAST 12 MONTHS: NONE ✓ GAIN LOSS NUMBER OF LBS: REASON:

OCCUPATION: Siding CLASS: 2A Average Monthly Salaried Earnings (Gross):

Average Monthly Self-Employed Earnings After Expenses: 7500 EXACT DUTIES: Rs. home - Siding

EMPLOYER: Self AREA CODE/ TELEPHONE: 803 513 0575 HIRE DATE: 1995

EMPLOYER ADDRESS (Street/ Rural Route): Same CITY: STATE: ZIP CODE:

BENEFICIARY NAME: Susanne Russell RELATIONSHIP: wife

SPOUSE TO BE INSURED

LAST: SUFFIX: FIRST: MI: SOCIAL SECURITY NUMBER:

AGE: BIRTHDATE (MMDDYYYY): STATE OF BIRTH: SEX: Height (Ft. In.): WEIGHT: Weight Change Last 12 Months: NONE GAIN LOSS Number of Lbs: REASON:

OCCUPATION: CLASS: Average Monthly Salaried Earnings (Gross): Average Monthly Self-Employed Earnings After Expenses: EXACT DUTIES:

EMPLOYER: AREA CODE/ TELEPHONE: HIRE DATE:

EMPLOYER ADDRESS: CITY: STATE: ZIP CODE:

BENEFICIARY NAME: RELATIONSHIP:

CHILDREN TO BE INSURED UNDER THIS POLICY

LAST NAME: FIRST NAME: MI: SEX: AGE: BIRTHDATE (MMDDYYYY):

JUL 11 2002

BUSINESS DEPT.

Please check one of the following: APP ORIGINAL 1900 ✓

I HEREBY APPLY FOR THE FOLLOWING COVERAGE FOR THE FAMILY MEMBERS NAMED ABOVE:

Form Series: Monthly ADB Riders - Not Available To Children

	PRIMARY INSURED MONTHLY AMT.	PRIMARY INSURED BENEFIT PERIOD	SPOUSE MONTHLY AMT	SPOUSE BENEFIT PERIOD
ACCIDENTAL DEATH BENEFIT (1933)	$	YEARS	$	YEARS
MOTOR VEHICLE ADB (1934)	$	YEARS	$	YEARS
COMMON CARRIER ADB (1935)	$	YEARS	$	YEARS
PREMIUM	$		$	

PAYMENT MODE:
ANNUAL
SEMIANNUAL
PAC ✓
PRD

ADB MODE PREMIUM $

OFFICE CODE	AGENT	NAME	%	OFFICE CODE	SUBAGENT CODE	NAME	%
44425	17316	RGT					

AMOUNT PAID: 829.00

P-A-1900 SC Rev. II 4.95

ORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS ENEFIT	INSURED	SPOUSE	CHILDREN
SABILITY ACCIDENT* 1901 ✓ 1941 Benefit Elimination Insured L 07 183.50 Spouse	500 per month	per month	
FF-JOB DISABILITY ACCIDENT* (1945) Benefit Elimination Insured Spouse	per month	per month	
HOSPITAL ACCIDENT 1902 1942	per day	per day	per day
SURGICAL ACCIDENT 1904 ✓ 1944 50.8	4000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946) 39.50	50 max	max	
ACCIDENT CONVALESCENT (1947) Multiple of Hospital Days:	per day	per day	per day
ACCIDENT INTENSIVE CARE (1948)	per day	per day	per day
PERSONAL CARE BENEFITS* 1949	per day	per day	
ACCIDENTAL DEATH 1903 ✓ 1943 71.25	75000 lump sum	lump sum	lump sum
DISABILITY SICKNESS* (1911) Benefit Elimination Insured Spouse	per month	per month	
HOSPITAL SICKNESS (1912)	per day	per day	per day
SURGICAL SICKNESS (1914)	max	max	max
SICKNESS CONVALESCENT (1957) Multiple of Hospital Days:	per day	per day	per day
SICKNESS INTENSIVE CARE (1964)	per day	per day	per day
OTHER RIDER:			
OTHER RIDER:			

ACCIDENT/SICKNESS PREMIUM (excl. Monthly ADB premium from front)	375.05 $ 27380	$	$
INFLATION PROTECTION YES	(Does NOT apply to Monthly ADB Riders included in the policy)		
A/S PREMIUM WITH INFLATION	$	$	$
PREMIUM INCL. MONTHLY ADB FROM FRONT	$	$	
INCREMENTAL COST	$		
SUBTOTAL	$ 27380	$	$
WAIVER OF PREMIUM YES	$ 458.92	113.87	TOTAL MODE PREMIUM: 4130
(Waiver of Premium will apply to any Monthly ADB Riders included)			
TOTAL PREMIUM - ALL COVERED INSUREDS	$ 36415	(INC ROP 90.33)	$ 4 (Includes ADB premium from front)

COMPLETE FOR ALL COVERAGES - GIVE DETAILS BELOW

		YES	NO
1.	Does any Family Member to be insured have any hospital, disability, emergency treatment or accident and sickness insurance currently in force, or do you or your spouse have an application for insurance pending?	✓	
2.	Does any Family Member to be insured have, or within the past five (5) years has any Family Member had, other coverage with Pennsylvania Life Insurance Company?	✓	
3.	Do you intend to replace any existing insurance with the insurance now applied for?		✓
4.	Are you or your spouse currently disabled?		✓
5.	Has any application for life or disability income insurance been declined, postponed, modified, cancelled or renewal refused within the past five (5) years?		✓

COMPLETE IF APPLYING FOR PERSONAL CARE BENEFITS - GIVE DETAILS BELOW

6.	During the past three years, have you or any family member applying for this benefit been confined to a wheelchair or to bed or been required to use a walker for more than 30 cumulative days as the result of an accident?		✓

COMPLETE IF APPLYING FOR ACCIDENT RIDERS ONLY - GIVE DETAILS BELOW

7.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?		✓
8.	Has any person named on this application been hospitalized in the last 6 months?		✓
9.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for injury?		✓
10.	To the best of your knowledge and belief, do you or any of the Family Members applying for coverage have, had, or been treated for any of the following within the past five (5) years:		
	a. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?		✓
	b. Disorder or disease of the muscles, bones, back or spine?		✓
11.	Other than already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any injury, or been advised to have a surgical operation which has not been performed?		✓
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?		✓

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 11:

Ques. No.	Name of Person	Company	Type (or Policy No.)	Doctor's Name and Address. Details of medical condition. If showing existing insurance, give benefit amounts, benefit and elimination periods.
1-2	Penn Life		# [redacted]9360	

PLETE IF APPLYING FOR ACCIDE[illegible] AND SICKNESS RIDERS—GIVE DET[illegible]S BELOW

	YES	NO
Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?		✓
Has any person named on this application been hospitalized in the last 6 months?		✓
Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for sickness or injury?		✓
Have you or your spouse lost 10 or more days from work during the last 12 months for sickness?		✓
Has any Family Member to be covered ever been institutionalized in a medical or mental facility for any reason?		✓
To the best of your knowledge and belief do you or any of the Family Members applying for coverage have, had or been treated for any of the following within the past five (5) years:		
a. Any deformity or loss of limb; or any disorder of the eyes, ears or throat?		✓
b. Diabetes, skin disease, hernia, or any glandular disorder?		✓
c. Nervous or emotional disorder or any disease of the brain or nervous system?		✓
d. Lung disorder or any disease of the respiratory system; or heart disease, murmur, abnormal blood pressure, stroke or any other disorder of the blood?		✓
e. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?		✓
f. Disorder or disease of the muscles, bones, back or spine; or disease or disorder of the kidneys or genito-urinary system?		✓
g. Disorder or disease of the gastrointestinal system; or liver, pancreas or gall bladder disorder?		✓
h. Cancer, tumor, cyst or growth of any type; or rectal disorder?		✓
18. Other than as already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
a. Received medical attention for any sickness or injury, or been advised to have a surgical operation which has not been performed?		✓
b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?		✓

GIVE DETAILS OF ANY "YES" ANSWER TO ANY PART OF QUESTIONS 12 THROUGH 18:

Ques. No.	Name of Person	Dates of onset and recovery	Nature of each injury, illness or consultation	Describe treatment or surgery	Name and address of doctor and/or hospital

NOTE: If all coverage applied for on the primary insured is declined, we will substitute the spouse (if applying for coverage) as the policy's primary insured.

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

[signature] 173416
Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application Signed in: Columbia SC 6/22/02
City State Date

I hereby apply to Pennsylvania Life Insurance Company for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company.

[signature]
Signature of Applicant

Signature of Spouse (if insured)

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank.

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 2610 Wycliff Road,
Raleigh, NC 27607
P.O. Box 10234, Raleigh, NC 27605
(919) 786-8900 - (800) 275-7366

APPLICATION FOR RETURN OF PREMIUM INSURANCE

DATE: MO. 6 DAY 27 YEAR 02

POLICY NO. (if applicable) [redacted]9360

Date of Birth: MO. DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: Mike Russell

ADDRESS: 1469 Dogwood Rd (Street) W. Columbia (City) SC 29172 (State Zip Code)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☑ RETURN OF PREMIUM 1900/APP. SERIES (PR-301) ☐ RETURN OF PREMIUM OTHER POLICY SERIES (PR-300)

Total Annual ROP Premium $ 113.87

Premium Mode PAC

Amount Paid With Application 20.50

COMPLETE FOR RETURN OF PREMIUM COVERAGE

1. Within the past two years have you or any covered family member submitted a claim on any accident or sickness policy with our Company? ☐ YES ☑ NO

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent 173416 Agent Code

Signature of 2nd Agent Agent Code

Dated at Columbia City SC State

I hereby apply to Pennsylvania Life Insurance Company for coverage to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company and all delivery requirements are met.

Signature of Primary Insured

JUL 17 2007

All premium checks must be payable to the Company; do not make checks payable to the agent or leave payee blank.

OFFICE CODE	AGENT CODE	CC	NAME	SUBAGENT CODE	CC	NAME	AMT. PAID
044425	173416		RGIC				20.50

P-A-300 FH 3-97

PENNSYLVANIA LIFE INSURANCE CO.

JULY 25 2002

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC 29172

Dear MR. RUSSELL:

Policy Number: [redacted]9360

We are pleased to advise you that the additional benefits for which you recently applied have been approved.

Your new policy schedule reflects the benefits currently in force. Please read the enclosed description of your benefits and attach the information to your policy.

If you have any questions regarding your new benefits or additional life, accident or health insurance needs, please contact your agent or call one of our customer service representatives toll-free at 1-800-275-7366.

Sincerely,

William E. Wehner

William E. Wehner, President
PENNSYLVANIA LIFE INSURANCE COMPANY

CC: 173416 GILL, RANDOLPH
091476 SC00044425

ACCIDENT SICKNESS PROTECTION

If You Qualify

Which Program Best Fits Your Needs?

Accident Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	ADB Amount	Options IP	Options WP	Premium Total
Mike Russell		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$

Incremental Cost $_____

Sickness Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	Options IP	Options WP	Premium Total
Mike Russell	29	$2500	days	yrs.	$	5000	$250			$ 931
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$

Incremental Cost $_____

Monthly Disability Benefit

Present Income	Disability Income Benefit
$4,000 per month	$2,000 per month
$3,600 per month	$1,800 per month
$3,000 per month	$1,500 per month
$2,400 per month	$1,200 per month
$2,000 per month	$1,000 per month
$1,600 per month	$800 per month
$1,200 per month	$600 per month
$800 per month	$400 per month
$400 per month	$200 per month

(Monthly benefit not to exceed 50% of present income)

ROA 659

Definitions, Exceptions and Limitations

INJURY means accidental bodily injury sustained directly and independently of disease or bodily infirmity, or any other cause while your coverage is in force.

SICKNESS means sickness or disease first manifesting itself more than 30 days after the issue date of the sickness rider and while your coverage is in force.

TOTAL DISABILITY means that you or your Covered Spouse are unable to engage in any employment or occupation for which you or your Covered Spouse are, or become, qualified by reason of education, training or experience.

TOTAL DISABILITY Coverage ends at age 65. However, if you are working full time your benefit will continue to age 70. When your Disability Benefit ends it will automatically convert to Hospital Confinement paid to you from the first day you are confined in a Hospital - even for life.

HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity, being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state – serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF (232.74) Mr. Russell Date 7/5/02 the sum of 232 Dollars 74 Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $ 931.-

LICENSED AGENT Randall A Gill

AGENT LICENSE NUMBER 173416

ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK [illegible]

CITY, STATE & ZIP CODE [illegible]

NAME OF ACCOUNT [illegible]

[illegible] — [illegible] 25

ACCOUNT NO.

[illegible] 6

BANK ROUTING NO.

DATE [illegible]

SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

7 (Month) 3 (Day) 22 (Year) on [illegible] (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

B.

NB RNWL

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

P-688

12 98

D: The Bank named above:

consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on ie accounts of persons who are responsible for these payments, the Company does hereby agree that:

1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and
2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and
3) Without limitation on the foregoing Indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and
4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By /Peter Kusev
J. Peter Kusev, Secretary

12.98

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this 5th day, month of July 2002

Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)		A. GROSS INCOME LAST YEAR
TITLE		B. OPERATING EXPENSES LAST YEAR
DUTIES		A-B= NET INCOME LAST YEAR
YEARS IN BUSINESS		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES	SS# [redacted]	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

City/State Date

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Pennsylvania Life Insurance Company has the right to deny benefits or rescind your policy.

Signature of Applicant

MDF 416 NC R ED 4-05

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this _____ day, month of _____, _____.

_____ _____

Name of Minor Child — Signature of Proposed Insured or Parent of Minor Child

_____ _____

Name of Minor Child — Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: South Trust bank

CITY, STATE & ZIP CODE: Folvan SC

NAME OF ACCOUNT: Suzanne C Russell & Michael J Russell

6 4 — ☐ ☐ 2 5

[redacted] ACCOUNT NO.

☐ 4 1 0

BANK ROUTING NO.

6/27/04

DATE SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

7 29 02 (Month) (Day) (Year) on Mike Russell (Name of Proposed Insured)

_____ (Month) (Day) (Year) on _____ (Name of Proposed Insured)

_____ (Month) (Day) (Year) on _____ (Name of Proposed Insured)

_____ (Month) (Day) (Year) on _____ (Name of Proposed Insured)

B.

NB RNWL

☐ ☐ Policy Number [redacted] 7260 effective for premiums due on and after 8 (Month) 1 (Day) 02 (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

P-688 12.98

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
J. Peter Kusev, Secretary

P-688

12.98

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL) Mike Russell		A. GROSS INCOME LAST YEAR 423,000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 330,000
DUTIES		A-B= NET INCOME LAST YEAR 93,000
YEARS IN BUSINESS		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES	SS#	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

City/State Date

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Pennsylvania Life Insurance Company has the right to deny benefits or rescind your policy.

Signature of Applicant

PRIVACY NOTICE TO OUR CUSTOMERS

THIS NOTICE IS FOR YOUR INFORMATION. NO RESPONSE IS REQUIRED.

Universal American Financial Corp and its subsidiary insurance companies: American Exchange Life Insurance Company, American Pioneer Life Insurance Company, American Progressive Life and Health Insurance Company of New York, Constitution Life Insurance Company, Marquette National Life Insurance Company, Peninsular Life Insurance Company, Pennsylvania Life Insurance Company, and Union Bankers Insurance Company strongly believe in protecting the confidentiality and security of information we collect about you. This notice refers separately to each of the companies by using the terms "us," "we," or "our." This notice describes our privacy policy and describes how we treat the information we receive ("Information") about you.

Why We Collect and How We Use Information: We collect and use Information for business purposes with respect to our insurance and other business relationships involving you. These business purposes include evaluating a request for our insurance or other products or services, evaluating benefit claims, administering our products or services and processing transactions requested by you. We may also use Information to offer you other products or services we provide.

How We Collect Information: We get most Information directly from you. The Information that you give us when applying for our products or services generally provides the Information we need. If we need to verify Information or need additional Information, we may obtain Information from third parties such as adult family members, employers, other insurers, consumer reporting agencies, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations or other personal characteristics as well as transactions with us or with others.

How We Protect Information: We treat Information in a confidential manner. Our employees are required to protect the confidentiality of Information. Employees may access Information only when there is an appropriate reason to do so, such as to administer or offer our products or services. We also maintain physical, electronic and procedural safeguards to protect Information; these safeguards comply with all applicable laws. Employees are required to comply with our established policies.

Information Disclosure: We may disclose any Information when we believe it necessary for the conduct of our business, or where disclosure is required by law. For example, Information may be disclosed to others, including independent agents or brokers who sell our products and services, to enable them to provide business services for us, such as helping us to evaluate requests for insurance or benefits, to perform general administrative activities such as maintaining existing accounts, or to otherwise assist us in servicing or processing an insurance product or service requested or authorized by you. Information may also be disclosed for audit or research purposes, or to law enforcement and regulatory agencies, for example, to help us prevent fraud. Information may be disclosed to others that are outside of our family of companies, such as companies that process data for us, companies that provide general administrative services for us, other insurers, and consumer reporting agencies. We will make other disclosures of Information as permitted by law.

We may also provide Information: (i) to others outside of our family of companies, such as marketing companies, independent agents and brokers, to assist us in offering our products and services to you, and (ii) to financial services companies outside of our family of companies with which we have a joint marketing agreement, such as an agreement with another insurer to enable us to offer you that insurer's products. Companies with which we share customer Information are required to maintain the confidentiality of that Information. We do not make any other disclosures of Information to other companies who may want to sell their products or services to you. For example, we will not sell your name to a catalog company. We may disclose any Information other than a consumer report or health Information for the purposes described in this paragraph.

Access to and Correction of Information: Generally, upon your written request, we will make available Information for your review. Information collected in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the Information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of Information.

Further Information: In addition to any other privacy notice we may provide, a recently enacted federal law established new privacy standards and requires us to provide this summary of our privacy policy annually. You may have additional rights under applicable laws. For additional Information regarding our privacy policy, please write to us.

Benefit Options Available*

Accident Total Disability

Accident Total Disability Benefit is paid to you each month while you are Totally Disabled due to injury from the date the elimination period ends, if any, up to the maximum benefit period allowed. Total Disability must start within 30 days of the accident. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability ends.)

Accident Surgical Benefit

Benefits payable to you for Surgery as a result of an Injury. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Accident Hospital Benefit

Hospital Benefits paid to you from the first day you are hospitalized as a result of injury for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Accidental Death Benefit

Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an Injury within 90 days of the accident.

Waiver of Premium Benefit - Accident

Premium Waived If You Are Totally Disabled from an accident.
If you are totally disabled for six months or more as a result of an Injury, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

Sickness Total Disability

Sickness Total Disability Benefit is paid to you while you are Totally Disabled as a result of Sickness. Benefits payable from the date the elimination period ends up to the maximum benefit period allowed. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability due to Sickness ends.)

Sickness Surgical Benefit

Benefits payable to you for Surgery as a result of Sickness. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Sickness Hospital Benefits

Hospital benefits paid to you from the first day you are hospitalized as a result of Sickness for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Waiver of Premium Benefit - Sickness

Premium Waived If You Are Totally Disabled from sickness.
If you are totally disabled for six months or more as a result of Sickness, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

Inflation Protection

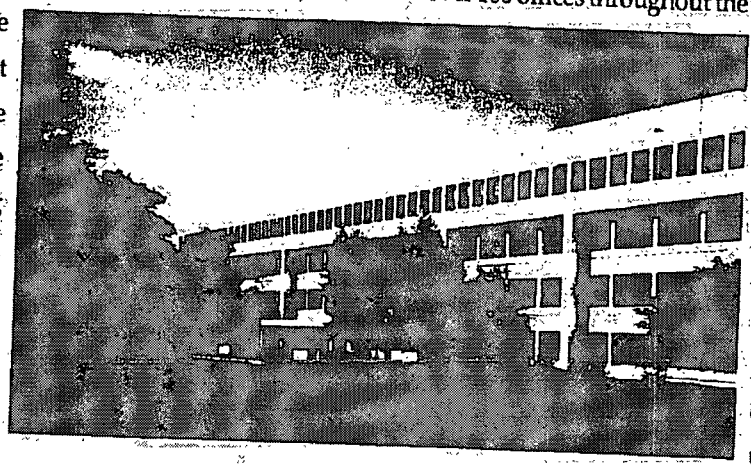
5% per year increase in benefits to 50% total increase after 10 yrs.

We will increase your daily benefit 5% per year for 10 years, if you have had continuous coverage. At the end of 10 years, your daily Injury and/or Sickness benefits are 150% of the original amount. The benefit for any claim will be fixed for its duration as of the date it starts.

**Benefit descriptions, definitions, exclusions and limitations may vary by state. Please refer to your policy/rider and the insert sheet enclosed. Benefits applied for are listed in your application.*

Safe, Solid, Stable

Pennsylvania Life Insurance Company is licensed to do business in 49 states, the District of Columbia and Canada. We underwrite, market and service a wide variety of insurance coverage including life, accident and health.



Our Policy-holder First Philosophy

With more than a half million policyholders, Pennsylvania Life Insurance Company's US operations has made substantial investments in technology in order to create and upgrade the kind of system required to provide every customer with top quality, responsive service. Although we manage more than 2,600 claims each month and pay more than $4,500,000 in benefits every month, we're only as good as the satisfaction of the last customer.

The Personal Approach

Pennsylvania Life is not a small company. With over 100 offices throughout the United States and Canada, we are a substantial company. But we haven't grown to our current size by ignoring our customers or creating large, unresponsive bureaucracies and annoying paperwork.

Our highly trained insurance professionals have built their success on your satisfaction. You'll find their personal approach to service is a welcome change to the way most businesses operate. It also means that your insurance representative will build a program of adequate, customized coverage based on your needs, rather than an off-the-shelf product line.

We've been in business for over 100 years because we're an insurance company that has never lost sight of why we're in business... to provide our customers with the insurance coverage they need when they need it the most.

PENNSYLVANIA LIFE INSURANCE CO.
600 Courtland Street, Orlando, Florida 32804

PB-1900 A/S Rev. 10.98

CN 96-0102

ORIGINAL

D.P.S. USE ONLY: 08070705 | Page 1 Of 1 | SOUTH CAROLINA TRAFFIC COLLISION REPORT FORM TR-310 (REV. 07/2001) | # Of Units: 2 | Amended - Attach Copy of Original Report | Corrected | Notified: 2134 | Arrived: 2200

Date: 06-18-2008 | Time: 2134 | County: 32 | Collision Location (Rt. # / Name): 26 | Miles: N/A | Dir.: N E S W | Nearest City or Town of: Cayce

Lane # / Dir.: 1 | Of: 1 | N E S W | Distance Offset: .10 Miles Feet | Direction: N E S W | 1- Interstate 2- US Primary 3- SC Primary 4- Secondary 5- County 6- Other | From: 321 | 0-Main 1-Alternate 2-Spur 6-Connection 7-Business 9-Other | ASRU code | MP/Grid

R.R. Id.: N/A | From: Ramp Only N E S W 1 - Entrance 2 - Exit | To: N E S W 1- Interstate 2- US Primary 3- SC Primary 4- Secondary 5- County 6- Other | Toward: 302 | Second Intersection (Rt. # / Name) | 0-Main 1-Alternate 2-Spur 6-Connection 7-Business 9-Other | Latitude: 33°56.0370" | Longitude: 81°04.4640"

X-561055

Driver/Pedestrian's Full Name: Russell-Micheal C
Unit #: 1 | Sex: M | Race: W | Street: 1469 Dogwood Rd
Birth Date: [redacted] | City, State, & Zip: West Columbia SC 29172
State: SC | Driver's License #: [redacted] | Insurance Company: Unknown
Year: 99 | Body: MTC | Vehicle Make: Har | VIN #: 1HDIC6P14WK114484
State: SC | Year: 2009 | License Plate #: ZWO229 | Owner's D.L. #: [redacted]
Home Telephone: (843) 955 0329 | Owner's Full Name: Russell-Micheal C
Bus. Telephone: ( ) N/A | Street: 1469 Dogwood Rd
Contributed To Collision: Yes / No | City, State, & Zip: West Columbia SC 29172
Estimated Speed: 60 | Speed Limit: 60 | C.D.L. Req: Yes / No | T/B S Req: Yes / No | Alc/Drg Info (see back): Yes / No
Summons #: D365378 | Code: 95 | Summons #: N/A | Code: | Towed By: Sandy Run

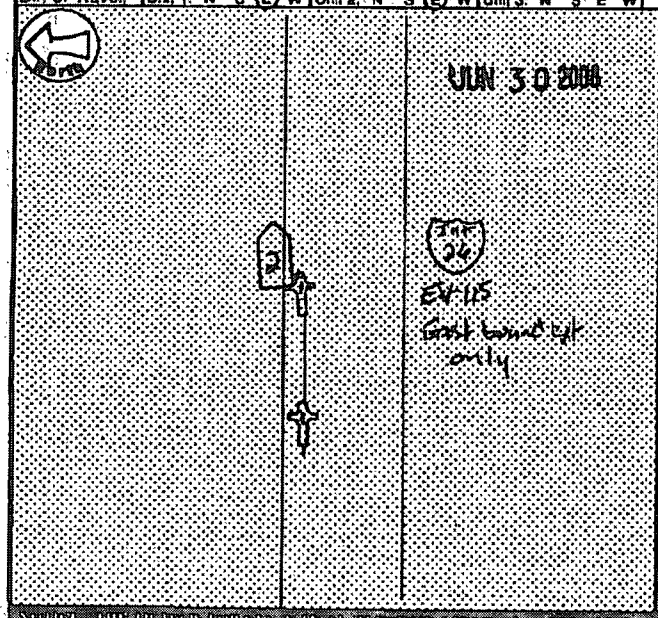
X-561056

Driver/Pedestrian's Full Name: Collins-Connie Lynn
Unit #: 2 | Sex: F | Race: W | Street: 1124 Starcrest Rd
Birth Date: [redacted] | City, State, & Zip: West Columbia SC 29172
State: SC | Driver's License #: [redacted] | Insurance Company: Travelers
Year: 2008 | Body: 4S | Vehicle Make: HYUN | VIN #: KMHDU46D18U281507
State: SC | Year: 2009 | License Plate #: 502TBH | Owner's D.L. #: [redacted]
Home Telephone: (803) 240 5045 | Owner's Full Name: Collins-Connie Lynn
Bus. Telephone: ( ) N/A | Street: 1124 Starcrest
Contributed To Collision: Yes / No | City, State, & Zip: West Columbia SC 29172
Estimated Speed: 0 | Speed Limit: 60 | C.D.L. Req: Yes / No | T/B S Req: Yes / No | Alc/Drg Info (see back): Yes / No
Summons #: D365375 | Code: 97 | Summons #: N/A | Code: | Towed By: Complete Auto

X-561057

Driver/Pedestrian's Full Name:
Unit #: N/A | Sex: | Race: | Street:
Birth Date: | City, State, & Zip:
State: | Driver's License #: | Insurance Company:
Year: | Body: | Vehicle Make: | VIN #:
Estimated Speed: | Speed Limit: | C.D.L. Req: Yes / No | T/B S Req: Yes / No | Alc/Drg Info (see back): Yes / No
Summons #: | Code: | Summons #: | Code: | Towed By:

Dir. of Travel: Unit 1: N S E W | Unit 2: N S E W | Unit 3: N S E W



JUN 30 2008

Unit 1 Dam.	Unit 2 Dam.	Unit 3 Dam.	Prop. Dam. 1	Prop. Dam. 2
$ 500.00	$ 500.00	$ N/A	$ N/A	$ N/A

Property Owner/Witness: N/A | Address: | Phone:
Property Owner/Witness: N/A | Address: | State: | Zip: | Phone:

Photo: Y (N) | Describe What Happened (Refer to Units by Number):
Unit #1 and Unit #2 were East bound on I-26 Exit ramp too US 321. Unit #2 stopped on the side with the rear corner still in the roadway. Unit #1 driving under the influence struck Unit #2 in the right rear.

NOTICE: THE DRIVER'S LICENSE SHALL BE REQUIRED FOR PURPOSES ONLY WHEN A VIOLATION OF THE MOTOR VEHICLE LAWS OF SOUTH CAROLINA IS CHARGED. THE ISSUANCE OF A SUMMONS IS MADE AT THE DISCRETION OF THE ARRESTING OFFICER.

Investigating Officer's Name	Rank	Badge #	Code	Date	Reviewer's Name	Rank	Internal Agency Code
W.C. Herndon	Trp	794	HP0100	06-18-2008	C.D. Ruth	Lieut	05977

DEFENDANT'S EXHIBIT 5

PLIC 0411

Unit	Date of Birth	Sex	Race	INJ	Seat	R/SD	A.B.D	Eject	LAI	Tran	Name	Street Address	Zip Code
1	[redacted]	M	W	3	3	01	00	7	3	1	1	Russell Michael C	1414 Dogwood Rd W. Columbia	29172
2	[redacted]	F	W	0	01	13	4	1	1	2			

Race: A - Asian/Pac/Ic Islander; B - African American; I - Alaskan Native or American Indian; H - Hispanic; W - Caucasian; O - Other; U - Unk.

a) Injury Status: 0- Not Injured; 1- Possible; 2- Non-incapacitating; 3- Incapacitating; 4- Fatal

b) Motorcycle Only — Head Injury: 1-Yes 2-No

Seating Loc.: 01 02 03 / 04 05 06 / 07 08 09; 20- Pedestrian; 30- Trailing Unit; 40- Bus or Van (4th row or Higher); 50- Other Enclosed Area (nontrailing); 51- Other Unenclosed Area (nontrailing); 60- Sleeper of Cab; 70- Riding on Unit Exterior; 80- Lap; 99- Unk/NA

Restraint/Safety Device: 00- None Used; 11- Shoulder Belt Only; 12- Lap Belt Only; 13- Shoulder & Lap Belt; 21- Child Safety Seat; 88- Other; 99- Unk

Air Bag Deployment / Switch: a) 1-Deployed Front 2-Deployed Side 3-Deployed Both 4-Not Deployed 7-Not Applicable 9-Deployment Unk.; b) 1- Switch in On Position 2- Switch in Off Position 3- No Switch 9- Unknown

Ejection: 1- Not Ejected; 2- Part. Ejected; 3- Tot. Ejected; 7- Not App.; 9- Unk.

Location After Impact: 1- Not Trapped; 2- Extricated (Mechanical Means); 3- Freed (non-mech.); 4- Not Applicable; 9- Unknown

a) Transported to Medical Facility: 1- Yes 2- No 3- Unknown

b) By: 1- EMS 2- Police 8- Other 9- Unk.

Pedestrian, Motor/Pedalcycle Only: 31- Helmet; 51- Reflective Clothing; 41- Protective Pads; 61- Lighting

Sequence of Events

1st Harmful	23					

Non-Collision: 01- Cargo/Equip Loss or Shift; 02- Cross Median/Center Line; 03- Downhill Runaway; 04- Equipment Failure; 05- Fire/Explosion; 06- Immersion; 07- Jackknife; 08- Overturn/Rollover; 09- Ran off Road Left; 10- Ran off Road Right; 11- Separation of Units; 12- Spilt; 18- Other Non-collision; 19- Unk. Non-collision

Collision Not Fixed: 20- Animal (Deer Only); 21- Animal (All Other); 29- Motor Veh. (In Transport); 39- Motor Veh. (Stopped); 49- Motor Veh. (Other Roadway); 65- Motor Veh. (Parked); 99- Pedalcycle; 27- Pedestrian; 28- Railway Veh; 29- Work Zone Maint. Equip.; 30- Other Movable Object; 99- Unk. Moveble Object

Collision Fixed Object: 40- Bridge Overhead Structure; 41- Bridge Pempet End; 42- Bridge Pier or Abutment; 43- Bridge Rail; 44- Culvert; 45- Curb; 46- Ditch; 47- Embankment; 48- Equipment; 49- Fence; 50- Guardrail End; 51- Guardrail Face; 52- Highway Traffic Sign Post; 53- Impact Attenuator/Crash Cushion; 54- Light/Luminaire Support; 55- Mail Box; 56- Median Barrier; 57- Overhead Sign Support; 58- Other (Post, Pole, Support, Etc.); 59- Other (Wall, Building, Tunnel, Etc.); 60- Tree; 61- Utility Pole; 62- Work Zone Maint. Equipment; 68- Other; 69- Unk.

Manner of Collision (Struck Veh.): 00- Not Coll. W/ Motor Veh.; 10- Rear End; 20- Head On; 30- Rear-to-Rear; 41- Angle; 42- Angle; 43- Angle; 50- Sideswipe Same Dir.; 60- Sideswipe Opposite Dir.; 70- Backed Into; 99- Unknown

1st / Most Deformed Area: 1st Deformed 03 05 3; Most Deformed 03 05 1

21- Pedestrian; 81- None; 82- Rollover; 83- Total; 84- Under Carriage; 88- Other; 99- Unk

Vehicle Type: 01- Automobile; 12- Pickup Truck; 13- Truck Tractor; 14- Other Truck; 15- Full Size Van; 18- Mini Van; 17- Sport Utility; 25- Motorcycle; 26- Other Motorbike; 27- Pedalcycle; 28- Animal Drawn Veh; 39- Animal (Ridden); 41- Pedestrian; 51- Train; 61- School Bus; 62- Passenger Bus; 98- Other; 99- Unk. (Hit and Run Only)

Alcohol / Drug Test Given: 1- Given - Known Results; 2- Given - Unusable; 3- Given - Pending; 4- None; 5- Refused

Special Use Only

Vehicle Use Code: 01- Personal; 02- Driver Training; 03- Construction/Maint.; 04- Ambulance; 05- Military; 06- Transport Passengers; 07- Transport Property; 08- Farm Use; 09- Wrecker or Tow; 10- Police; 11- Government; 12- Fire Fighting; 13- Logging; 18- Other; 41- Pedestrian

Test Type: 1- Breath (Alc Only); 2- Blood; 3- Urine; 4- Serum; 5- Other

Drug Results: 1- Amphetamines; 2- Cocaine; 3- Marijuana; 4- Opiates; 5- PCP; 8- Other

Underride/Override: 1- Under- Compartment Intrusion; 2- Under- No Intrusion; 3- Under- Unknown; 4- Over- MV in Transport; 5- Over- Other Vehicle; 6- None; 9- Unk

Extent of Deformity: 0- None/Minor; 1- Functional Damage; 2- Disabling Damage; 3- Severe/Totaled; 4- Not Applicable; 9- Unk

Vehicle Attachment: 1- None; 2- Mobile Home; 3- Semi-Trailer; 4- Utility Trailer; 5- Farm Trailer; 6- Trailer w/Boat; 7- Camper Trailer; 8- Towed Motor Vehicle; 9- Petroleum Tanker; A- Lowboy Trailer; B- Autocarrier Trailer; C- Other Trailer; D- Flat Bed; E- Twin Trailers; F- Other

Alc Test Results: A1- ; A2- ; A3-

Trafficway: 1- Two-way, Not Divided; 2- Two-way, Divided, Unprotected Median; 3- Two-way, Divided Barrier; 4- One-Way; 8- Other

A: 1- Curb; 2- Island; 3- Median; 4- Roadside; 5- Roadway; 6- Shoulder; 7- Sidewalk; 8- Utility Pole; 9- Unk

B: X-walk; 1-Y 2-N 9-U

1st Harmful Event Loc.: 5

Action Prior to Impact: 01- Backing; 02- Changing Lanes; 03- Entering Traffic Lane; 04- Leaving Traffic Lane; 05- Making U-turn; 06- Movements Essentially Straight Ahead; 07- Overtaking/Passing; 08- Parked; 09- Slowing or Stopped in Traffic; 10- Turning Left; 11- Turning Right; 88- Other; 99- Unk

(Vehicle): 21- Approaching/Leaving Vehicle; 22- Entering/Crossing Location; 23- Playing/Working on Vehicle; 24- Pushing Vehicle; 25- Standing; 26- Walking, Playing, Cycling; 27- Working

(Non-motorist)

Road Character: 1- Straight - Level; 2- Straight - On Grade; 3- Straight - Hillcrest; 4- Curve - Level; 5- Curve - On Grade; 6- Curve - Hillcrest

Road Surface Condition: 1- Dry; 2- Wet; 3- Snow; 4- Slush; 5- Ice; 6- Contaminate; 7- Water (Standing, etc.); 8- Other; 9- Unk

Traffic Control Type: 01- Stop and Go Light; 02- Flashing Traffic Signal; 11- RR (X-bucks, Lights & Gates); 12- RR (X-bucks & Lights); 13- RR (X-bucks Only); 21- Officer or Flagman; 22- Oncoming Emergency Vehicle; 31- Pavement Markings (only); 41- Stop Sign; 42- School Zone Sign; 43- Yield Sign; 44- Work Zone; 45- Other Warning Signs; 51- Flashing Beacon; 99- None

Weather Condition: 1- Clear (no adverse conditions); 2- Rain; 3- Cloudy; 4- Sleet, Hail; 5- Snow; 6- Fog, Smog, Smoke; 7- Blowing Sand, Oil, Dirt or Snow; 8- Severe Crosswinds; 9- Unk

Light Condition: 1- Daylight; 2- Dawn; 3- Dusk; 4- Dark (Lighting Unspecified); 5- Dark (Street Lamp Lit); 6- Dark (Street Lamp Not Lit); 7- Dark (No lights)

School Bus Involved: 3

Junction Type: 01- Crossover; 02- Driveway; 03- Five/More Points; 04- Four-way Intersection; 05- Railway Grade Crossing; 07- Shared Use Paths or Trail; 08- T-Intersection; 09- Traffic Circle; 12- Y-Intersection; 13- Roundabout; 99- Unk.

1- Yes, Directly; 2- Yes, Indirectly; 3- No; 9- Unk.

1- Before 1st Sign; 2- Advanced Warning Area; 3- Transition Area; 4- Activity Area; 5- Termination Area

Work Zone: 1- Yes 2- No

Work Zone Location

Work Zone Type: 1- Shoulder/Median Work; 2- Lane Shift/Crossover; 3- Intermittent/Moving Work; 4- Lane Closure; 8- Other; 9- Unk.

Workers Present: 1- Yes 2- No

Primary Contributing Factors

Driver: 01- Disregarded Signs, Signals, Etc; 02- Distracted/Inattention; 03- Driving Too Fast for Conditions; 04- Exceeded Authorized Speed Limit; 05- Failed to Yield Right of Way; 06- Ran off Road; 07- Fatigued/Asleep; 08- Followed Too Closely; 09- Made an Improper Turn; 10- Medical Related; 11- Operating Vehicle in Erratic, Reckless, or Negligent Manner; 12- Aggressive Operation of Vehicle; 13- Over-correcting/Over-steering; 14- Swerving to Avoiding Object; 15- Wrong Side or Wrong Way; 16- Under the Influence; 17- Vision Obscured (Within Unit); 18- Improper Lane Usage/Change; 20- Other Improper Action; 29- Unk.

Roadway: 30- Debris; 31- Non-highway Work; 32- Obstruction in Roadway; 33- Road Surface Condition (i.e., Wet); 34- Rut, Holes, Bumps; 35- Shoulders (None, Low, Soft, High); 36- Traffic Control Device (i.e., Missing); 37- Work Zone (Constr./Maint./Utility); 38- Worn, Travel-Polished Surface; 48- Other; 49- Unk

Non-Motorist: 50- Inattentive; 51- Lying &/or Illegally in Roadway; 52- Failure to Yield R. of W.; 53- Not Visible (Dark Clothing); 54- Disregard Signs, Signals, Etc.; 55- Improper Crossing; 56- Darting; 58- Other; 59- Unk.; 57- Wrong Side of Road; 66- Under the Influence; 67- Other Person Under Influence

Environmental: 60- Animal in Road; 61- Glare; 62- Obstruction; 63- Weather Cond; 68- Other; 69- Unk.

Vehicle Defect: 70- Brakes; 71- Steering; 72- Power Plant; 73- Tires/Wheel; 74- Lights; 75- Signals; 76- Windows/Shield; 77- Restraint System; 78- Truck Coupling; 79- Cargo; 80- Fuel System; 88- Other; 89- Unk.

PLIC 0412

KSM 0645 08-070705

Mail FR-10 to: SC Department of Motor Vehicles, Office of Financial Responsibility (803) 896-5000, PO Box 1498, Blythewood, SC 29016

South Carolina Department of Motor Vehicles (DMV)
FR-10 (REV. 10/05)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company Representatives can submit your insurance information at WWW.SCARF.COM

Date	Time	County	Interstate 4- Secondary 2- US Primary 5- County 3- SC Primary	Collision Location (Rt. # / Name)	Main line 6-Connector 7-Alternate 8-Business 9-Spur	Miles:	Dir. N E S W	Near City or Town of:
6-19-2006	2121	32		& 26		N/A		Cayce

To Vehicle Owner/ Operator: Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

FR10 Audit No. X-561055

Driver/Pedestrian's Full Name: Russell - Michael C

Unit # 1 | Sex M | Race W | Street: 1469 Dogwood Rd
Birth Date [redacted] | City, State, & Zip: West Columbia SC 29172
State SC | Driver's License # [redacted] | Insurance Company:
Year 94 | Body MTC | Vehicle Make Jeep | VIN # 1HDJCP1WXRJ144811
State SC | Year 2006 | License Plate # ZNO 729 | Owner's D.L. # [redacted]
Home Telephone (843) 955 0325 | Owner's Full Name: Russell - Michael C
Bus. Telephone ( ) N/A | Street: 1469 Dogwood Rd
Contributed To Collision: Yes (No) | City, State, & Zip: West Columbia SC 29172

FR10 Audit No. X-561056

Driver/Pedestrian's Full Name: Collins - Connie Lynn

Unit # 2 | Sex F | Race W | Street: 1124 Starcrest Rd
Birth Date [redacted] | City, State, & Zip: West Columbia SC 29172
State SC | Driver's License # [redacted] | Insurance Company: Travelers
Year 2006 | Body 4S | Vehicle Make Hyundai | VIN # KMHDU46D86U281567
State SC | Year 2006 | License Plate # 553TBH | Owner's D.L. # [redacted]
Home Telephone ( ) | Owner's Full Name: Collins - Connie Lynn
Bus. Telephone ( ) | Street: 1124 Starcrest
Contributed To Collision: (Yes) No | City, State, & Zip: West Columbia SC 29172

FR10 Audit No. X-561057

Driver/Pedestrian's Full Name: THE ST. PAUL COMPANIES

Unit # | Sex | Race | Street: THE ST. PAUL COMPANIES
Birth Date | City, State, & Zip: JUN 29 2006
State | Driver's License # | Insurance Company:
Year | Body | Vehicle Make | VIN # COLUMBIA SC OFFICE
State | Year | License Plate # | Owner's D.L. #
Home Telephone ( ) | Owner's Full Name
Bus. Telephone ( ) | Street
Contributed To Collision: Yes No | City, State, & Zip

All Units Insurance Information
(to be completed by Investigating Officer)

Automobile liability insurance information for Unit #
Company Name: Travelers | Area Code/Phone Number: 800 1842 3675
Agency Name: OM 1993 | Policy Number: [redacted]

Automobile liability insurance information for Unit #
Company Name | Area Code/Phone Number ( )
Agency Name | Policy Number

Automobile liability insurance information for Unit #
Company Name | Area Code/Phone Number ( )
Agency Name | Policy Number

Automobile Liability Insurance Information

Notice of Requirement Accepted | Signature | Y N Refused to Affix Signature? | Y N Vehicle Subject to Registration in SC?

To be completed by Driver / Owner or Agent or Company Representative. This form should not be mailed to DMV if liability insurance has been cancelled. Use only if vehicle is not insured.

Reference to Unit #: 2, I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below-stated insurance company on the date of the collision.

The information on this form is signed under penalty of perjury and is subject to criminal penalties and/or civil liability for the person making a false statement.

Insurance Company	Policy #	Signature	Date
Travelers Home & Marine	980852954	[redacted]	6/29
Beginning Date: 3/29/06	Ending Date: 9/29/06	Policy Holder: Connie Collins	Agent's Telephone (803) 758-2601

Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, disregard the above portion.

- Check here if a Form SR-23, Fleet Policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle.
- Check here if a certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate number: SI -
- Check here if liability insurance was not in effect to comply with South Carolina statutory requirements. | Signature | Date

Form FR-10 Not Issued: Section 56-10-520

No FR-10 Issued to Operator/ Owner of Unit #
Summons Issued to:
For operating or [illegible] the operation of an uninsured vehicle | Summons Number: | Signature | Date

RECEIVED JUL 14 2006

Investigating Officer's Name	Rank	Badge #	Code	Date	Reviewer's Name	Rank	Internal Agency Code
[redacted]	Trp	734	[illegible]	06-19-2006	[redacted]		Responsibility

DRIVER / OWNER

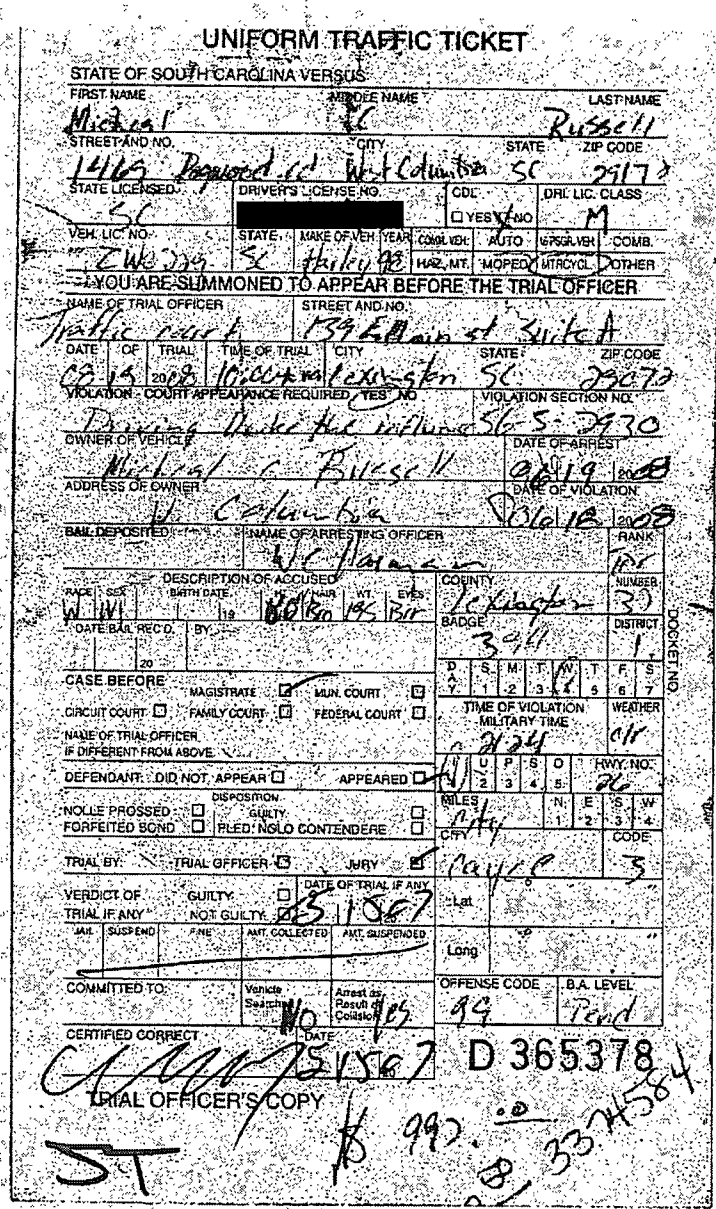
KSM 0645

From SCDMV

DEFENDANT'S EXHIBIT 6

PLIC 0413

DEFENDANT'S EXHIBIT 7



UNIFORM TRAFFIC TICKET

STATE OF SOUTH CAROLINA VERSUS

FIRST NAME: Michael | MIDDLE NAME: C | LAST NAME: Russell

STREET AND NO.: 1469 Pearwood rd | CITY: West Columbia | STATE: SC | ZIP CODE: 29172

STATE LICENSED: SC | DRIVER'S LICENSE NO.: [redacted] | CDL: ☐ YES ☒ NO | DRI. LIC. CLASS: M

VEH. LIC. NO.: TWC 329 | STATE: SC | MAKE OF VEH: Harley | YEAR: 98 | COMM VEH: ☐ | AUTO: ☐ | 15 PSGR VEH: ☐ | COMB: ☐ | HAZ. MT.: ☐ | MOPED: ☐ | MTRCYCL: ☒ | OTHER: ☐

YOU ARE SUMMONED TO APPEAR BEFORE THE TRIAL OFFICER

NAME OF TRIAL OFFICER: Traffic court | STREET AND NO.: 139 E Main st Suite A

DATE OF TRIAL: 08 19 2008 | TIME OF TRIAL: 10:00 am | CITY: Lexington | STATE: SC | ZIP CODE: 29072

VIOLATION - COURT APPEARANCE REQUIRED: ☐ YES ☒ NO | VIOLATION SECTION NO.: 56-5-3930

Driving Under the influ | 56-5-3930

OWNER OF VEHICLE: Michael C Russell | DATE OF ARREST: 06 19 2008

ADDRESS OF OWNER: W Columbia | DATE OF VIOLATION: 06 19 2008

BAIL DEPOSITED: | NAME OF ARRESTING OFFICER: J C Harman | RANK: Tpr

DESCRIPTION OF ACCUSED: RACE: W | SEX: M | BIRTH DATE: [redacted] | HT.: 6' | HAIR: Brn | WT.: 195 | EYES: Brn

COUNTY: Lexington | NUMBER: 30 | DOCKET NO.

DATE BAIL REC'D.: | BY: | BADGE: 3241 | DISTRICT: 1

DAY: S M T W T F S | 1 2 3 4 5 6 7

CASE BEFORE: MAGISTRATE ☒ MUN. COURT ☐ | CIRCUIT COURT ☐ FAMILY COURT ☐ FEDERAL COURT ☐

TIME OF VIOLATION MILITARY TIME: 2124 | WEATHER: clr

NAME OF TRIAL OFFICER IF DIFFERENT FROM ABOVE:

DEFENDANT: DID NOT APPEAR ☐ APPEARED ☐ | U 2 P 3 S 4 O 5 | HWY. NO.: 26

DISPOSITION: NOLLE PROSSED ☐ GUILTY ☐ | FORFEITED BOND ☐ PLED: NOLO CONTENDERE ☐

MILES: Atty | N 1 E 2 S 3 W 4

TRIAL BY: TRIAL OFFICER ☒ JURY ☐ | CITY: Cayce | CODE: 3

VERDICT OF TRIAL IF ANY: GUILTY ☐ NOT GUILTY ☐ | DATE OF TRIAL IF ANY: 08 15 2008

Lat: ° ' "

JAIL	SUSPEND	FINE	AMT. COLLECTED	AMT. SUSPENDED

Long: ° ' "

COMMITTED TO: | Vehicle Searched: NO | Arrest as Result of Collision: NO | OFFENSE CODE: 99 | B.A. LEVEL: Test

CERTIFIED CORRECT: | DATE: 8/15/08 | D 365378

TRIAL OFFICER'S COPY

ST $ 992.00 8 337458

UNIFORM TRAFFIC TICKET

STATE OF SOUTH CAROLINA VERSUS

FIRST NAME: Michael | MIDDLE NAME: C | LAST NAME: Russell

STREET AND NO.: 1469 Dearwood | CITY: West Columbia | STATE: SC | ZIP CODE: 29172

STATE LICENSED: SC | DRIVER'S LICENSE NO.: [redacted] | CDL: ☐ YES ☒ NO | DRI. LIC. CLASS: M

VEH. LIC. NO.: TWC 329 | STATE: SC | MAKE OF VEH: Harley | YEAR: 98 | COMM VEH: ☐ | AUTO: ☐ | 15 PSGR VEH: ☐ | COMB: ☐ | HAZ. MT.: ☐ | MOPED: ☐ | MTRCYCL: ☒ | OTHER: ☐

YOU ARE SUMMONED TO APPEAR BEFORE THE TRIAL OFFICER

NAME OF TRIAL OFFICER: Traffic court | STREET AND NO.: 139 E Main st Suite A

DATE OF TRIAL: 08 19 2008 | TIME OF TRIAL: 10:00 am | CITY: Lexington | STATE: SC | ZIP CODE: 29072

VIOLATION - COURT APPEARANCE REQUIRED: ☐ YES ☒ NO | VIOLATION SECTION NO.: 56-1-130

Expired motorcycle DL | 56-1-130

OWNER OF VEHICLE: Michael C Russell | DATE OF ARREST: 06 19 2008

ADDRESS OF OWNER: W Columbia | DATE OF VIOLATION: 06 19 2008

BAIL DEPOSITED: None | NAME OF ARRESTING OFFICER: J C Harman | RANK: Tpr

DESCRIPTION OF ACCUSED: RACE: W | SEX: M | BIRTH DATE: [redacted] | HT.: 6' | HAIR: Brn | WT.: 195 | EYES: Brn

COUNTY: Lexington | NUMBER: 29 | DOCKET NO.

DATE BAIL REC'D.: | BY: | BADGE: 3241 | DISTRICT: 1

DAY: S M T W T F S | 1 2 3 4 5 6 7

CASE BEFORE: MAGISTRATE ☒ MUN. COURT ☐ | CIRCUIT COURT ☐ FAMILY COURT ☐ FEDERAL COURT ☐

TIME OF VIOLATION MILITARY TIME: 2124 | WEATHER: clr

NAME OF TRIAL OFFICER IF DIFFERENT FROM ABOVE:

DEFENDANT: DID NOT APPEAR ☐ APPEARED ☒ | U 1 P 3 S 4 O 5 | HWY. NO.: 26

DISPOSITION: NOLLE PROSSED ☐ GUILTY ☒ | FORFEITED BOND ☐ PLED: NOLO CONTENDERE ☐

MILES: | N 1 E 2 S 3 W 4

TRIAL BY: TRIAL OFFICER ☒ JURY ☐ | CITY: Cayce | CODE: 3

VERDICT OF TRIAL IF ANY: GUILTY ☐ NOT GUILTY ☐ | DATE OF TRIAL IF ANY: 08 15 2008

Lat: ° ' "

JAIL	SUSPEND	FINE	AMT. COLLECTED	AMT. SUSPENDED
	237	50		

Long: ° ' "

COMMITTED TO: | Vehicle Searched: NO | Arrest as Result of Collision: NO | OFFENSE CODE: 87 | B.A. LEVEL:

CERTIFIED CORRECT: | DATE: 8/15/08 | D 365377

TRIAL OFFICER'S COPY

ST 237 50 337458 8/15/08

PLIC 0414

ROA 675

ADVISEMENT OF IMPLIED CONSENT RIGHTS

Michael C. Rosell [redacted]

Subject's Name (Print) | Date of Birth

[redacted] | SC

Driver's License Number | State Licensed

DRIVING UNDER THE INFLUENCE ADVISEMENT

(A) Will test be video recorded? If answer is Yes, start here → ◆ Inform subject of ~~video recording~~.
◆ Advise subject of Miranda rights.
If answer is No, start here → ◆ Inform subject of the type (breath, blood, urine) samples requested.

(B) Then read the following advisement to subject:

- ◆ You are under arrest for Driving Under the Influence (DUI), Section 56-5-2930, South Carolina Code of Laws 1976, as amended.
- ◆ The arresting officer has directed that samples be taken for alcohol and/or drug testing.
- ◆ The samples will be taken and tested according to Section 56-5-2950 and SLED policies.
- ◆ You do not have to take the tests or give the samples, but if you refuse to submit to the tests, your privilege to drive in South Carolina must be suspended or denied for at least ninety (90) days and your refusal may be used against you in court.
- ◆ If you take the tests or give the samples and have an alcohol concentration of eight one-hundredths of one percent (0.08%) or more, you may instead be charged with Driving with an Unlawful Alcohol Concentration (DUAC), Section 56-5-2933.
- ◆ If you have an alcohol concentration of fifteen one-hundredths of one percent (0.15%) or more, your privilege to drive in South Carolina must be suspended for at least thirty (30) days.
- ◆ You have the right to have a qualified person of your own choosing conduct additional independent tests at your expense and the officer, upon request, must provide you affirmative assistance.
- ◆ You have the right to request an administrative hearing within thirty (30) days of the issuance of the notice of suspension.
- ◆ If you do not request an administrative hearing or if your suspension is upheld at the administrative hearing, you must enroll in an Alcohol and Drug Safety Action Program.

If applicable, perform the following procedures:

(C) Check subject's mouth and remove any foreign material. (Not required if a refusal has occurred.)
(D) Time stamp Breath Alcohol Analysis Test Report. (Not required if a refusal has occurred.)
(E) Observe subject for a minimum of twenty (20) minutes before collecting breath sample. (Not required if a refusal has occurred.)
(F) Enter biographical data into BAC DataMaster. (Required for all tests, including refusals.)

FELONY DRIVING UNDER THE INFLUENCE ADVISEMENT

(B) Will test be video recorded? If answer is Yes, start here → ◆ Inform subject of video recording.
◆ Advise subject of Miranda rights.
If answer is No, start here → ◆ Inform subject of the type (breath, blood, urine) samples requested.

(B) Then read the following advisement to subject:

- ◆ You are under arrest for Felony Driving Under the Influence (Felony DUI), Section 56-5-2945, South Carolina Code of Laws 1976, as amended, or a law enforcement officer has probable cause to believe that you have violated this section.
- ◆ The officer has directed that samples be taken for alcohol and/or drug testing.
- ◆ The samples will be taken and tested according to Section 56-5-2950 and SLED policies.
- ◆ Pursuant to Section 56-5-2946, you must submit to either one or a combination of chemical tests for the purpose of determining the presence of alcohol, drugs, or a combination of alcohol and drugs.
- ◆ The resistance, obstruction, or opposition to testing pursuant to Section 56-5-2946 is evidence admissible at trial.
- ◆ If your tests or samples have an alcohol concentration of fifteen one-hundredths of one percent (0.15%) or more, your privilege to drive in South Carolina must be suspended for at least thirty (30) days.
- ◆ You have the right to have a qualified person of your own choosing conduct additional independent tests at your expense and the officer, upon request, must provide you affirmative assistance.
- ◆ You have the right to request an administrative hearing within thirty (30) days of the issuance of the notice of suspension.
- ◆ If you do not request an administrative hearing or if your suspension is upheld at the administrative hearing, you must enroll in an Alcohol and Drug Safety Action Program.

If applicable, perform the following procedures:

(C) Check subject's mouth and remove any foreign material.
(D) Time stamp Breath Alcohol Analysis Test Report.
(E) Observe subject for a minimum of twenty (20) minutes before collecting breath sample.
(F) Enter biographical data into BAC DataMaster.

DEFENDANT'S EXHIBIT B

William C. Harmon | Unable to sign

Officer's Name (Print) | Subject's Signature (Received Copy)

[redacted] | 08-18-2008 2355

Officer's Signature | Date | Time

SLED Permanent Form # [illegible], April 2004

MR_Lex Med Ctr_0187

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

APPLICATION FOR INSURANCE

POLICYHOLDER

DATE: 11/9/1999 NOV 24 1999

MAIL PREMIUM NOTICES: ☐ BUSINESS ☒ RESIDENCE ☐ INCREASE

POLICY NO. [redacted]9360 ☑ NEW ☐ CURRENT

INSURED NAME

LAST	SUFFIX	FIRST	MI	SOCIAL SECURITY NUMBER
Russell		Mike		[redacted]

ADDRESS (Street/Rural Route): 1469 Dogwood Rd

ADDRESS (Line 2):

CITY	STATE	ZIP CODE	COUNTY
W. Columbia	SC	29172	Columbia

AREA CODE/ TELEPHONE	BEST TIME/ DAY TO CALL	AGE	BIRTHDATE (MMDDYYYY)	STATE OF BIRTH	SEX
8039530329	Am	20	[redacted]	IL	M

HEIGHT (Ft. In.)	WEIGHT	WEIGHT CHANGE LAST 12 MONTHS	NUMBER OF LBS	REASON
5 10	170	NONE ☒ GAIN ☐ LOSS ☐		

OCCUPATION	CLASS	Average Monthly Salaried Earnings (Gross)	Average Monthly Self-Employed Earnings After Expenses	EXACT DUTIES
Siding Applicator	2A		916.6	Siding Houses

EMPLOYER	AREA CODE/ TELEPHONE	HIRE DATE
SELF	same	5yrs

EMPLOYER ADDRESS (Street/ Rural Route)	CITY	STATE	ZIP CODE
same	same		

BENEFICIARY NAME	RELATIONSHIP
Susan Russell	wife

SPOUSE TO BE INSURED

LAST	SUFFIX	FIRST	MI	SOCIAL SECURITY NUMBER

AGE	BIRTHDATE (MMDDYYYY)	STATE OF BIRTH	SEX	Height (Ft. In.)	WEIGHT	Weight Change Last 12 Months	Number of Lbs	REASON
						NONE ☐ GAIN ☐ LOSS ☐		

OCCUPATION	CLASS	Average Monthly Salaried Earnings (Gross)	Average Monthly Self-Employed Earnings After Expenses	EXACT DUTIES

EMPLOYER	AREA CODE/ TELEPHONE	HIRE DATE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

BENEFICIARY NAME	RELATIONSHIP

CHILDREN TO BE INSURED UNDER THIS POLICY

LAST NAME	FIRST NAME	MI	SEX	AGE	BIRTHDATE (MMDDYYYY)

Please check one of the following: APP ☐ / ORIGINAL 1900 ☑

I HEREBY APPLY FOR THE FOLLOWING COVERAGE FOR THE FAMILY MEMBERS NAMED ABOVE:

Form Series: Monthly ADB Riders - Not Available To Children

	PRIMARY INSURED MONTHLY AMT.	PRIMARY INSURED BENEFIT PERIOD	SPOUSE MONTHLY AMT.	SPOUSE BENEFIT PERIOD
ACCIDENTAL DEATH BENEFIT (1933)	$	YEARS	$	YEARS
MOTOR VEHICLE ADB (1934)	$	YEARS	$	YEARS
COMMON CARRIER ADB (1935)	$	YEARS	$	YEARS
PREMIUM	$		$	

PAYMENT MODE:
ANNUAL ☐
SEMIANNUAL ☐
PAC ☒
PRD ☐

ADB MODE PREMIUM $

OFFICE CODE	AGENT	NAME	%	OFFICE CODE	SUBAGENT CODE	NAME	%	AMOUNT PAID
04413	17111	AGT						282.00

P-A-1900 SC Rev. II 4.95

DEFENDANT'S EXHIBIT 9

PLIC 0542

FORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 [X] 1941 [ ] Benefit / Elimination — Insured: Benefit 6, Elimination 07 — Spouse: 734	2000 per month	per month	
OFF-JOB DISABILITY ACCIDENT* (1945) Benefit / Elimination — Insured / Spouse	per month	per month	
HOSPITAL ACCIDENT 1902 [ ] 1942 [ ]	per day	per day	per day
SURGICAL ACCIDENT 1904 [X] 1944 [ ] 11.5	1000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946)	max	max	
ACCIDENT CONVALESCENT (1947) Multiple of Hospital Days: [ ]	per day	per day	per day
ACCIDENT INTENSIVE CARE (1948)	per day	per day	per day
PERSONAL CARE BENEFITS* 1949 [ ]	per day	per day	
ACCIDENTAL DEATH 1903 [X] 1943 [ ] 230	25000 lump sum	lump sum	lump sum
DISABILITY SICKNESS* (1911) Benefit / Elimination — Insured / Spouse	per month	per month	
HOSPITAL SICKNESS (1912)	per day	per day	per day
SURGICAL SICKNESS (1914)	max	max	max
SICKNESS CONVALESCENT (1957) Multiple of Hospital Days: [ ]	per day	per day	per day
SICKNESS INTENSIVE CARE (1964)	per day	per day	per day
OTHER RIDER: [ ]			
OTHER RIDER: [ ]			

ACCIDENT/SICKNESS PREMIUM (excl. Monthly ADB premium from front)	$ 7C925	$	$
INFLATION PROTECTION [ ] YES (Does NOT apply to Monthly ADB Riders included in the policy)			
A/S PREMIUM WITH INFLATION	$	$	$
PREMIUM INCL. MONTHLY ADB FROM FRONT	$	$	
INCREMENTAL COST	$ 1504		
SUBTOTAL	$ 78925	$	$
WAIVER OF PREMIUM [ ] YES	$		TOTAL MODE PREMIUM:
(Waiver of Premium will apply to any Monthly ADB Riders included)			
TOTAL PREMIUM - ALL COVERED INSUREDS (Includes Inflation, Waiver and any Monthly ADB Premium)	$ 104305 (Incorp)		$ 9387 (Includes ADB premium from front)

P-A-1900 SC Rev. II 4.95 *Disability Income, Emergency Treatment and Personal Care benefits NOT available to children

PLIC 0543

COMPLETE FOR ALL COVERAGES - GIVE DETAILS BELOW

		YES	NO
1.	Does any Family Member to be insured have any hospital, disability, emergency treatment or accident and sickness insurance currently in force, or do you or your spouse have an application for insurance pending?	☐	☑
2.	Does any Family Member to be insured have, or within the past five (5) years has any Family Member had, other coverage with Pennsylvania Life Insurance Company?	☐	☑
3.	Do you intend to replace any existing insurance with the insurance now applied for?	☐	☑
4.	Are you or your spouse currently disabled?	☐	☑
5.	Has any application for life or disability income insurance been declined, postponed, modified, cancelled or renewal refused within the past five (5) years?	☐	☑

COMPLETE IF APPLYING FOR PERSONAL CARE BENEFITS - GIVE DETAILS BELOW

6.	During the past three years, have you or any family member applying for this benefit been confined to a wheelchair or to bed or been required to use a walker for more than 30 cumulative days as the result of an accident?	☐	☐

COMPLETE IF APPLYING FOR ACCIDENT RIDERS ONLY - GIVE DETAILS BELOW

7.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?	☐	☑
8.	Has any person named on this application been hospitalized in the last 6 months?	☐	☑
9.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for injury?	☐	☑
10.	To the best of your knowledge and belief, do you or any of the Family Members applying for coverage have, had, or been treated for any of the following within the past five (5) years:		
	a. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?	☐	☑
	b. Disorder or disease of the muscles, bones, back or spine?	☐	☑
11.	Other than already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any injury, or been advised to have a surgical operation which has not been performed?	☐	☑
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?	☐	☑

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 11:

Ques. No.	Name of Person	Company	Type (or Policy No.)	Doctor's Name and Address. Details of medical condition. If showing existing insurance, give benefit amounts, benefit and elimination periods.

COMPLETE IF APPLYING FOR ACCI[illegible]T AND SICKNESS RIDERS—GIVE DE[illegible]LS BELOW

		YES	NO
12.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?	☐	☐
13.	Has any person named on this application been hospitalized in the last 6 months?	☐	☐
14.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for sickness or injury?	☐	☐
15.	Have you or your spouse lost 10 or more days from work during the last 12 months for sickness?	☐	☐
16.	Has any Family Member to be covered ever been institutionalized in a medical or mental facility for any reason?	☐	☐
17.	To the best of your knowledge and belief do you or any of the Family Members applying for coverage have, had or been treated for any of the following within the past five (5) years:		
	a. Any deformity or loss of limb; or any disorder of the eyes, ears or throat?	☐	☐
	b. Diabetes, skin disease, hernia, or any glandular disorder?	☐	☐
	c. Nervous or emotional disorder or any disease of the brain or nervous system?	☐	☐
	d. Lung disorder or any disease of the respiratory system; or heart disease, murmur, abnormal blood pressure, stroke or any other disorder of the blood?	☐	☐
	e. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?	☐	☐
	f. Disorder or disease of the muscles, bones, back or spine; or disease or disorder of the kidneys or genito-urinary system?	☐	☐
	g. Disorder or disease of the gastrointestinal system; or liver, pancreas or gall bladder disorder?	☐	☐
	h. Cancer, tumor, cyst or growth of any type; or rectal disorder?	☐	☐
18.	Other than as already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any sickness or injury, or been advised to have a surgical operation which has not been performed?	☐	☐
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?	☐	☐

GIVE DETAILS OF ANY "YES" ANSWER TO ANY PART OF QUESTIONS 12 THROUGH 18:

Ques. No.	Name of Person	Dates of onset and recovery	Nature of each injury, illness or consultation	Describe treatment or surgery	Name and address of doctor and/or hospital

NOTE: If all coverage applied for on the primary insured is declined, we will substitute the spouse (if applying for coverage) as the policy's primary insured.

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

[illegible] 11111

Signature of Licensed Agent — Agent #

Signature of Licensed Agent — Agent #

Application Signed in:

Columbia — SC — 11/15/88

City — State — Date

I hereby apply to Pennsylvania Life Insurance Company for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company.

⊗ [illegible]

Signature of Applicant

Signature of Spouse (if insured)

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank. The coverage you are applying for is not Workers' Compensation; a replacement for Workers' Compensation; nor an alternative to Workers' Compensation.

P-A-1900 SC Rev. II 4.95

PLIC 0545

ROA 680

PENNSYLVANIA LIFE INSURANCE CO.

RECEIVED
NOV 24 1999
NEW BUSINESS DEPT.

Home Office: Lemoyne, Pennsylvania
Executive Office: 2610 Wycliff Road,
Raleigh, NC 27607
P.O. Box 10234, Raleigh, NC 27605
(919) 786-8900 - (800) 275-7366

APPLICATION FOR RETURN OF PREMIUM INSURANCE

DATE: MO. 11 DAY 15 YEAR 99

POLICY NO. (if applicable) [redacted] 9360

Date of Birth: MO. [redacted] DAY YEAR

Social Security No: [redacted]

PRIMARY INSURED NAME: Mark Mike Russell

ADDRESS: 1469 Dogwood Rd (Street) W. Columbia (City) SC (State) 29172 (Zip Code)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:
- [X] RETURN OF PREMIUM 1900/APP SERIES (PR-301)
- [ ] RETURN OF PREMIUM OTHER POLICY SERIES (PR-300)

Total Annual ROP Premium $ 250.00

Premium Mode 23.29

Amount Paid With Application 69.87

COMPLETE FOR RETURN OF PREMIUM COVERAGE

1. Within the past two years have you or any covered family member submitted a claim on any accident or sickness policy with our Company? [ ] YES [X] NO

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent — Agent Code 17111

Signature of 2nd Agent — Agent Code

Dated at — City — State

I hereby apply to Pennsylvania Life Insurance Company for coverage to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company and all delivery requirements are met.

Signature of Primary Insured

All premium checks must be payable to the Company; do not make checks payable to the agent or leave payee blank.

OFFICE CODE	AGENT CODE	CC	NAME	SUBAGENT CODE	CC	NAME	AMT. PAID
Y4413	17111		Cof				69.87

P-A-300 Ed. 3-97

PLIC 0546

A & H APPLICATION RECEIPT

SECTION A

MEDICAID ELIGIBILITY

(To be completed when the "Medicaid Eligibility" question is not on the application.)

DO YOU HAVE A CURRENT MEDICAID ELIGIBILITY CARD?

YES ☐ NO ☒

Applicant's Signature	Date	Agent's Signature
[signature]	11/15/99	[signature]

SECTION B

CERTIFICATION OF DELIVERY

1. ☐ Outline(s) of Coverage for the insurance applied for.

   (To be completed when an Outline of Coverage is given to the Applicant.)

2. ☐ "Guide to Health Insurance for People with Medicare" booklet.

   (To be completed when the "Buyer's Guide" is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

3. ☐ Medicare Duplication of Coverage Notice.

   (To be completed when the Notice is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

I acknowledge receipt of the items checked above.

Applicant's Signature	Date	Agent's Signature

For Instant Issue only, complete the following:

Policy Number: _____

Rider Control Number: _____

ATTACH TO APPLICATION

Form MC-200(SC) Ed. 8-96

PLIC 0547

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

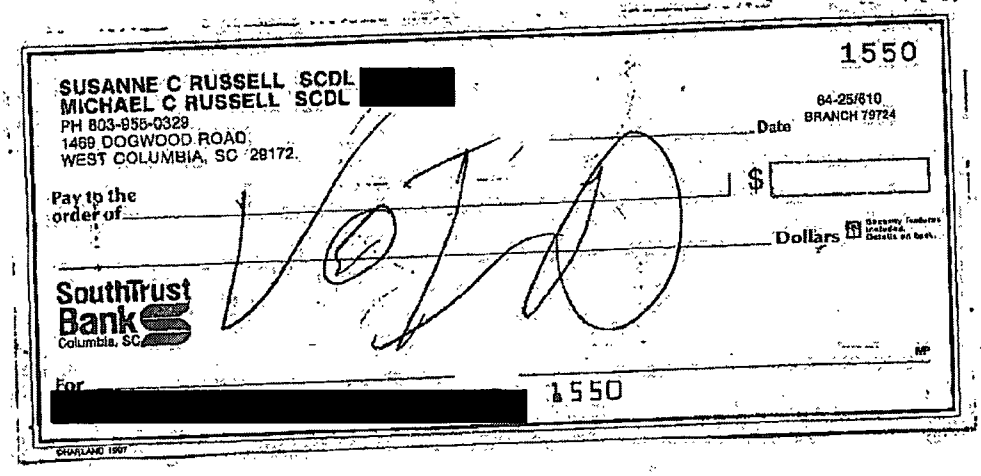
(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
James Lillie, Secretary



P-688 12.98

PLIC 0548

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: South Trust Bank

CITY, STATE & ZIP CODE: West Columbia SC 29172

NAME OF ACCOUNT: Michael Russell

6Y – 0025

ACCOUNT NO. [redacted]

0610

BANK ROUTING NO.

11-18-98 X [signature]

DATE — SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

11 (Month) 18 (Day) 98 (Year) on Michael Russell (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

B.

NB RNWL

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

P-688 12.98

(COMPANY COPY)

PLIC 0549

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: P.O. Box 10234, Raleigh, North Carolina 27605

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at P. O. Box10234, Raleigh, North Carolina 27605-0234.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this 19 day, month of November, 1999

	[signature]
Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PLIC 0550

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL) Russell Mike		A. GROSS INCOME LAST YEAR 160,000
TITLE Sider		B. OPERATING EXPENSES LAST YEAR 50,000
DUTIES Siding Houses		A – B = NET INCOME LAST YEAR 110,000
YEARS IN BUSINESS 5yrs		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 5	SS# [redacted]	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

[signature] 17111
Signature of Licensed Agent — Agent #

Signature of Licensed Agent — Agent #

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

X [signature]
Signature of Applicant

Application signed at:
Columbia SC, 11/15/98
City/State — Date

MCF-416 ED. 4-95

PLIC 0551

Definitions, Exceptions and Limitations

INJURY means accidental bodily injury sustained directly and independently of disease or bodily infirmity, or any other cause while your coverage is in force.

SICKNESS means sickness or disease first manifesting itself more than 30 days after the issue date of the sickness rider and while your coverage is in force.

TOTAL DISABILITY means that you or your Covered Spouse are unable to engage in any employment or occupation for which you or your Covered Spouse are, or become, qualified by reason of education, training or experience.

TOTAL DISABILITY Coverage ends at age 65. However, if you are working full time your benefit will continue to age 70. When your Disability Benefit ends it will automatically convert to Hospital Confinement paid to you from the first day you are confined in a Hospital - even for life.

HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity, being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state -- serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF _____ Date _____, _____ the sum of _____ Dollars _____ Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $ _____

LICENSED AGENT _____

AGENT LICENSE NUMBER _____

ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

DEFENDANT'S EXHIBIT 10

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

JUL 09 2002

APPLICATION FOR INSURANCE

POLICYHOLDER

DATE: 06 27 2002 | MAIL PREMIUM NOTICES: ☐ BUSINESS ☑ RESIDENCE | ☑ INCREASE | POLICY NO. [redacted] 9360 | ☐ NEW ☑ CURRENT

INSURED NAME

LAST	SUFFIX	FIRST	MI	SOCIAL SECURITY NUMBER
Russell		Michael		[redacted]

ADDRESS (Street/Rural Route)	ADDRESS (Line 2)
1469 Dogwood Rd	

CITY	STATE	ZIP CODE	COUNTY
West Columbia	SC	29172	Lexington

AREA CODE/ TELEPHONE	BEST TIME/ DAY TO CALL	AGE	BIRTHDATE (MMDDYYYY)	STATE OF BIRTH	SEX
8039550329	eve	29	[redacted]	IL	M

HEIGHT (Ft. In.)	WEIGHT	WEIGHT CHANGE LAST 12 MONTHS	NUMBER OF LBS	REASON
5 09	160	NONE ☑ GAIN ☐ LOSS ☐		

OCCUPATION	CLASS	Average Monthly Salaried Earnings (Gross)	Average Monthly Self-Employed Earnings After Expenses	EXACT DUTIES
Siding	2A		7500	Rts. Insure - Siding

EMPLOYER	AREA CODE/ TELEPHONE	HIRE DATE
Self	803 513 0575	1995

EMPLOYER ADDRESS (Street/ Rural Route)	CITY	STATE	ZIP CODE
Same			

BENEFICIARY NAME	RELATIONSHIP
SUSANNE Russell	Wife

SPOUSE TO BE INSURED

LAST	SUFFIX	FIRST	MI	SOCIAL SECURITY NUMBER

AGE	BIRTHDATE (MMDDYYYY)	STATE OF BIRTH	SEX	Height (Ft. In.)	WEIGHT	Weight Change Last 12 Months	Number of Lbs	REASON
						NONE ☐ GAIN ☐ LOSS ☐		

OCCUPATION	CLASS	Average Monthly Salaried Earnings (Gross)	Average Monthly Self-Employed Earnings After Expenses	EXACT DUTIES

EMPLOYER	AREA CODE/ TELEPHONE	HIRE DATE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

BENEFICIARY NAME	RELATIONSHIP

CHILDREN TO BE INSURED UNDER THIS POLICY

LAST NAME	FIRST NAME	MI	SEX	AGE	BIRTHDATE (MMDDYYYY)

JUL 11 2002
BUSINESS DEPT.

Please check one of the following: APP ☐ ORIGINAL 1900 ☑

I HEREBY APPLY FOR THE FOLLOWING COVERAGE FOR THE FAMILY MEMBERS NAMED ABOVE:

Form Series: Monthly ADB Riders - Not Available To Children

	PRIMARY INSURED MONTHLY AMT	PRIMARY INSURED BENEFIT PERIOD	SPOUSE MONTHLY AMT	SPOUSE BENEFIT PERIOD
ACCIDENTAL DEATH BENEFIT (1933)	$	YEARS	$	YEARS
MOTOR VEHICLE ADB (1934)	$	YEARS	$	YEARS
COMMON CARRIER ADB (1935)	$	YEARS	$	YEARS
PREMIUM	$		$	

PAYMENT MODE:
ANNUAL ☐
SEMIANNUAL ☐
PAC ☑
PRD ☐

ADB MODE PREMIUM $

OFFICE CODE	AGENT	NAME	%	OFFICE CODE	SUBAGENT CODE	NAME	%	AMOUNT PAID
044425	173416	RGI						8290

P-A-1900 SC Rev. II 4.95

DEFENDANT'S EXHIBIT 11

PLIC 0558

FORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 ☑ 1941 ☐ Benefit: Insured L, Spouse ____ Elimination: 07	500 per month	per month	
OFF-JOB DISABILITY ACCIDENT* (1945) Benefit: Insured ____, Spouse ____ Elimination: ____	per month	per month	
HOSPITAL ACCIDENT 1902 ☐ 1942 ☐	per day	per day	per day
SURGICAL ACCIDENT 1904 ☑ 1944 ☐	4000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946)	50 max	max	
ACCIDENT CONVALESCENT (1947) Multiple of Hospital Days: ☐	per day	per day	per day
ACCIDENT INTENSIVE CARE (1948)	per day	per day	per day
PERSONAL CARE BENEFITS* 1949 ☐	per day	per day	
ACCIDENTAL DEATH 1903 ☑ 1943 ☐	75000 lump sum	lump sum	lump sum
DISABILITY SICKNESS* (1911) Benefit: Insured ____, Spouse ____ Elimination: ____	per month	per month	
HOSPITAL SICKNESS (1912)	per day	per day	per day
SURGICAL SICKNESS (1914)	max	max	max
SICKNESS CONVALESCENT (1957) Multiple of Hospital Days: ☐	per day	per day	per day
SICKNESS INTENSIVE CARE (1964)	per day	per day	per day
OTHER RIDER: ____			
OTHER RIDER: ____			

ACCIDENT/SICKNESS PREMIUM (excl. Monthly ADB premium from front) 375.05	$ 27380	$	$
INFLATION PROTECTION ☐ YES (Does NOT apply to Monthly ADB Riders included in the policy)			
A/S PREMIUM WITH INFLATION	$	$	$
PREMIUM INCL. MONTHLY ADB FROM FRONT	$	$	
INCREMENTAL COST	$		
SUBTOTAL	$ 27380	$	$
WAIVER OF PREMIUM ☐ YES	$ 458.92	113.87	TOTAL MODE PREMIUM: 4130
(Waiver of Premium will apply to any Monthly ADB Riders included)		(INC NOT 90.33)	
TOTAL PREMIUM - ALL COVERED INSUREDS	$ 36415		$ 15
Includes Inflation, Waiver and any Monthly ADB Premium			(Includes ADB premium from front)

P-A-1900 SC Rev. II 4.95 *Disability Income, Emergency Treatment and Personal Care benefits NOT available to children 2

PLIC 0559

ROA 689

COMPLETE FOR ALL COVERAGES - /E DETAILS BELOW

		YES	NO
1.	Does any Family Member to be insured have any hospital, disability, emergency treatment or accident and sickness insurance currently in force, or do you or your spouse have an application for insurance pending?	☑	☐
2.	Does any Family Member to be insured have, or within the past five (5) years has any Family Member had, other coverage with Pennsylvania Life Insurance Company?	☑	☐
3.	Do you intend to replace any existing insurance with the insurance now applied for?	☐	☑
4.	Are you or your spouse currently disabled?	☐	☑
5.	Has any application for life or disability income insurance been declined, postponed, modified, cancelled or renewal refused within the past five (5) years?	☐	☑

COMPLETE IF APPLYING FOR PERSONAL CARE BENEFITS - GIVE DETAILS BELOW

6.	During the past three years, have you or any family member applying for this benefit been confined to a wheelchair or to bed or been required to use a walker for more than 30 cumulative days as the result of an accident?	☐	☐

COMPLETE IF APPLYING FOR ACCIDENT RIDERS ONLY - GIVE DETAILS BELOW

7.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?	☐	☑
8.	Has any person named on this application been hospitalized in the last 6 months?	☐	☑
9.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for injury?	☐	☑
10.	To the best of your knowledge and belief, do you or any of the Family Members applying for coverage have, had, or been treated for any of the following within the past five (5) years:		
	a. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?	☐	☑
	b. Disorder or disease of the muscles, bones, back or spine?	☐	☑
11.	Other than already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any injury, or been advised to have a surgical operation which has not been performed?	☐	☑
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?	☐	☑

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 11:

Ques. No.	Name of Person	Company	Type (or Policy No.)	Doctor's Name and Address. Details of medical condition. If showing existing insurance, give benefit amounts, benefit and elimination periods.
1, 2	Ronn L. K	#	[redacted]9360	

P-A-1900 SC Rev. II 4-95

3

PLIC 0560

ROA 690

COMPLETE IF APPLYING FOR ACCIDENT AND SICKNESS RIDERS—GIVE DETAILS BELOW

		YES	NO
12.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?	☐	☑
13.	Has any person named on this application been hospitalized in the last 6 months?	☐	☑
14.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for sickness or injury?	☐	☑
15.	Have you or your spouse lost 10 or more days from work during the last 12 months for sickness?	☐	☑
16.	Has any Family Member to be covered ever been institutionalized in a medical or mental facility for any reason?	☐	☑
17.	To the best of your knowledge and belief do you or any of the Family Members applying for coverage have, had or been treated for any of the following within the past five (5) years:		
	a. Any deformity or loss of limb; or any disorder of the eyes, ears or throat?	☐	☑
	b. Diabetes, skin disease, hernia, or any glandular disorder?	☐	☑
	c. Nervous or emotional disorder or any disease of the brain or nervous system?	☐	☑
	d. Lung disorder or any disease of the respiratory system; or heart disease, murmur, abnormal blood pressure, stroke or any other disorder of the blood?	☐	☑
	e. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?	☐	☑
	f. Disorder or disease of the muscles, bones, back or spine; or disease or disorder of the kidneys or genito-urinary system?	☐	☑
	g. Disorder or disease of the gastrointestinal system; or liver, pancreas or gall bladder disorder?	☐	☑
	h. Cancer, tumor, cyst or growth of any type; or rectal disorder?	☐	☑
18.	Other than as already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any sickness or injury, or been advised to have a surgical operation which has not been performed?	☐	☑
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?	☐	☑

GIVE DETAILS OF ANY "YES" ANSWER TO ANY PART OF QUESTIONS 12 THROUGH 18:

Ques. No.	Name of Person	Dates of onset and recovery	Nature of each injury, illness or consultation	Describe treatment or surgery	Name and address of doctor and/or hospital

NOTE: If all coverage applied for on the primary insured is declined, we will substitute the spouse (if applying for coverage) as the policy's primary insured.

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

[signature] 173416
Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application Signed in:
Columbia SC 6/22/02
City State Date

I hereby apply to Pennsylvania Life Insurance Company for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company.

[signature]
Signature of Applicant

Signature of Spouse (if Insured)

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank. The coverage you are applying for is not Workers' Compensation; a replacement for Workers' Compensation; nor an alternative to Workers' Compensation.

P-A-1900 SC Rev. II 4.95

PLIC 0561

ROA 691

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 2610 Wycliff Road,
Raleigh, NC 27607
P.O. Box 10234, Raleigh, NC 27605
(919) 786-8900 - (800) 275-7366

APPLICATION FOR RETURN OF PREMIUM INSURANCE

DATE

MO.	DAY	YEAR
6	27	02

POLICY NO. (if applicable) [redacted] 9360

Date of Birth: MO. DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: Mike Russell

ADDRESS: 1469 Dogwood Rd (Street) W. Columbia (City) SC 29172 (State Zip Code)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☑ RETURN OF PREMIUM 1900/APP SERIES (PR-301) ☐ RETURN OF PREMIUM OTHER POLICY SERIES (PR-300)

Total Annual ROP Premium $ 113.87

Premium Mode PAC

Amount Paid With Application 20.50

COMPLETE FOR RETURN OF PREMIUM COVERAGE

1. Within the past two years have you or any covered family member submitted a claim on any accident or sickness policy with our Company? ☐ YES ☑ NO

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent — Agent Code 173416

Signature of 2nd Agent — Agent Code

Dated at Columbia (City) SC (State)

I hereby apply to Pennsylvania Life Insurance Company for coverage to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company and all delivery requirements are met.

Signature of Primary Insured

JUL 1 1 2002

All premium checks must be payable to the Company; do not make checks payable to the agent or leave payee blank.

OFFICE CODE	AGENT CODE	CC	NAME	SUBAGENT CODE	CC	NAME	AMT. PAID
044425	173416		RCLC				20.50

P-A-300 Ed. 3-97

PLIC 0562

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2810 Wycliff Road, Raleigh, North Carolina 27607

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL) Mike Russell		A. GROSS INCOME LAST YEAR 420,000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 330,000
DUTIES install vinyl siding		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS 7		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 6	SS# [redacted]	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent [signature] Agent # 6/27/22

Signature of Licensed Agent Agent #

Application signed at:

Columbia SC 6/27/22

City/State Date

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Pennsylvania Life Insurance Company has the right to deny benefits or rescind your policy.

[signature]

Signature of Applicant

MCF-416 NC-P ED. 4-95

PLIC 0563

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

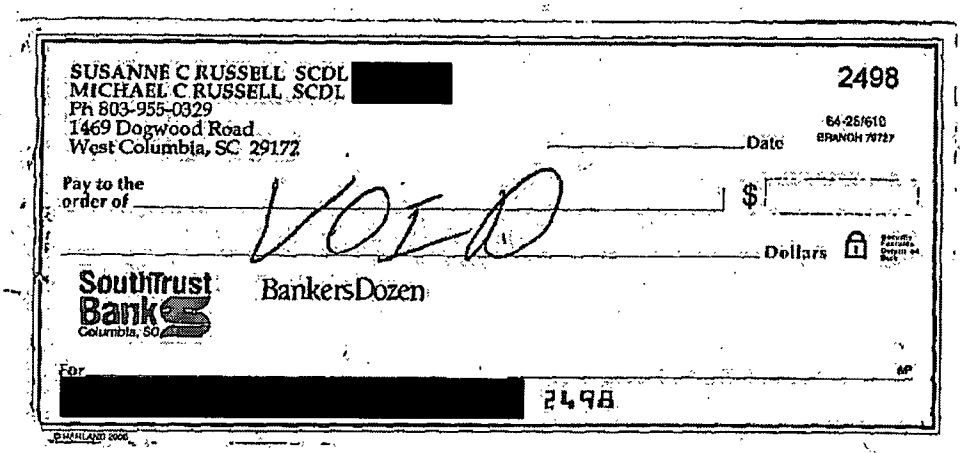
(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
J. Peter Kusev, Secretary



12.98

P-688

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: SouthTrust Bank

CITY, STATE & ZIP CODE: Columbia SC

NAME OF ACCOUNT: Suzanne C Russell & Michael C Russell

6 4 – ☐ ☐ 2 5 — [redacted] ACCOUNT NO.

☐ 6 1 0
BANK ROUTING NO.

6/27/02 ✓ Mike Russell
DATE SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

6 (Month) 27 (Day) 02 (Year) on Mike Russell (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

B.

NB	RNWL			
☐	☑	Policy Number [redacted]936	effective for premiums due on and after	8 (Month) 19 (Day) 02 (Year)
☐	☐	Policy Number	effective for premiums due on and after	(Month) (Day) (Year)
☐	☐	Policy Number	effective for premiums due on and after	(Month) (Day) (Year)
☐	☐	Policy Number	effective for premiums due on and after	(Month) (Day) (Year)
☐	☐	Policy Number	effective for premiums due on and after	(Month) (Day) (Year)
☐	☐	Policy Number	effective for premiums due on and after	(Month) (Day) (Year)

P-688 12.98

(COMPANY COPY)

PLIC 0565

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half ($2^{1/2}$) years.

Signed this 27th day, month of June 2002

Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PLIC 0566

A & H APPLICATION RECEIPT

SECTION A

MEDICAID ELIGIBILITY

(To be completed when the "Medicaid Eligibility" question is not on the application.)

DO YOU HAVE A CURRENT MEDICAID ELIGIBILITY CARD?

YES ☐ NO ☑

Applicant's Signature | 6/27/02 Date | Agent's Signature

SECTION B

CERTIFICATION OF DELIVERY

1. ☐ Outline(s) of Coverage for the insurance applied for.

   (To be completed when an Outline of Coverage is given to the Applicant.)

2. ☐ "Guide to Health Insurance for People with Medicare" booklet.

   (To be completed when the "Buyer's Guide" is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

3. ☐ Medicare Duplication of Coverage Notice.

   (To be completed when the Notice is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

I acknowledge receipt of the items checked above.

Applicant's Signature | Date | Agent's Signature

For Instant Issue only, complete the following:

Policy Number: _____

Rider Control Number: _____ _____ _____

ATTACH TO APPLICATION

Form MC-200(SC) Ed. 8-96

PLIC 0567

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Wayne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL) Russell Mike		A. GROSS INCOME LAST YEAR 420000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 330,000
DUTIES Install and Sidin		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS 6		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 8	SS# [redacted]	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

[signature] 173416

Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

Lexington SC 7/8/05

City/State Date

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Pennsylvania Life Insurance Company has the right to deny benefits or rescind your policy.

[signature]

Signature of Applicant

MCF-416 NC-P ED 4-95

PLIC 0568

Definitions, Exceptions and Limitations

INJURY means accidental bodily injury sustained directly and independently of disease or bodily infirmity, or any other cause while your coverage is in force.

SICKNESS means sickness or disease first manifesting itself more than 30 days after the issue date of the sickness rider and while your coverage is in force.

TOTAL DISABILITY means that you or your Covered Spouse are unable to engage in any employment or occupation for which you or your Covered Spouse are, or become, qualified by reason of education, training or experience.

TOTAL DISABILITY Coverage ends at age 65. However, if you are working full time your benefit will continue to age 70. When your Disability Benefit ends it will automatically convert to Hospital Confinement paid to you from the first day you are confined in a Hospital - even for life.

HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity, being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania
EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state – serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF (232.74) Mike Russell Date 7/5/02 the sum of 232 Dollars 74 Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $ 931-

LICENSED AGENT Lawrence A Gill

AGENT LICENSE NUMBER 173416

ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

DEFENDANT'S EXHIBIT 12

PENNSYLVANIA LIFE INSURANCE CO.

CHANGE OF BENEFITS AGREEMENT

I acknowledge the fact that I have changed my coverage on policy # [redacted]9360 as follows:

- ☐ I am reducing my basic policy coverage from _____ to _____.
- ☐ I am reducing my existing rider(s) that were effective _____, from _____ to _____.
- ☒ I have deleted benefit rider(s) that were effective:

301 0066
R.O.P.
Dated 11/19/99 + 7/19/2002
+ 8/19/99

Effective Date of Changes 4-20-09.

Insured's Signature

7-20-09
Date

Michael Russell

II-19 (MC) Original - *Home Office* Yellow - *Processing Office* Pink - *Insured* 7-96

IMAGING
AUG 11 2009

DEFENDANT'S EXHIBIT 12

ROA 700

PLIC 0581

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) injury causes Total Disability which starts within 30 days after the date of the accident and continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under the Regular and Personal Care of a Physician; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Policy Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care of a Physician continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one accident.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Policy was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy.

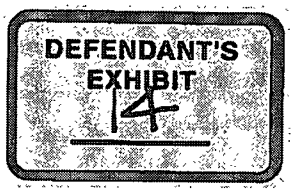
HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if injury results in you or your Covered Spouse being confined in a Hospital as a resident patient under the Regular and Personal Care of a Physician. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for Total Disability end.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65



RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods: (a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser

Secretary

William E. Wehner

President

PR-1901

12.90

Russell 0153

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENTAL DEATH BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

If Injury results in the death of a Covered Family Member within 90 days of the accident, we will pay the Accidental Death Benefit shown in the Policy Schedule to the designated Beneficiary.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for death which results from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J Peter Keuser

Secretary

William E Wehner

President

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT SURGICAL INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is a resident patient in a Hospital; and
2. The Hospital stay is for a covered Injury; and
3. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Accident Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity, except that no amount is payable for dental treatment unless such treatment results from accidental bodily injury to natural teeth or gums. If a covered surgical procedure is performed on an Insured who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Accident Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one accident.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for covered surgical procedures resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser — Secretary

William E. Wehner — President

PR-1904 SC 10.91

ACCIDENT SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc.

URINARY TRACT

Nephrectomy	$400.00
Nephroctomy, nephropexy, ureterotomy	$250.00
Cystoscopy for diagnosis only	$100.00
Operation for repair of urethra	$ 50.00

SPINE

Fracture of any vertebrae requiring removal of a portion thereof (coccyx and process excepted)	$500.00
Fracture of any vertebral process requiring removal	$250.00
Removal of nucleus pulposus or intervertebral disc	$250.00
Bone graft or fusion operation	$200.00
Fracture of sacrum or coccyx requiring open operation or removal of coccyx	$ 75.00

EXTREMITIES-UPPER

Amputation:	
At shoulder joint or resection of shoulder	$325.00
Of arm or forearm at or above wrist or resection of elbow or wrist	$200.00
Of entire finger or any part of hand	$ 50.00
Of part of finger (one or two phalanges)	$ 50.00
Fractures, Reduction:	
Of bones of arm or forearm	$150.00
Of any of the bones of wrist, hand or fingers	$ 50.00
Dislocation:	
Reduction of dislocation of shoulder or elbow joint	$ 50.00

EXTREMITIES-LOWER

Amputation:	
At hip joint	$500.00
Of thigh or leg at or above ankle – resection of knee or ankle joint	$250.00
Of any part of foot or complete toe	$ 50.00
Of any part of toe	$ 50.00
Fractures, Reduction:	
Of femur or pelvic bones, removal of semi-lunar cartilage	$150.00
Of bone or bones of leg	$125.00
Of any of the bones of tarsus or patella	$ 75.00
Of any other bones of foot	$ 50.00
Dislocations:	
Reduction of dislocation of hip or knee joint	$ 50.00

The amounts shown for fractures in Extremities-Upper and Lower are for simple fracture. For fractures requiring open reduction the maximum will be one and one-half (X 10) times the amount for the corresponding simple fracture. For a fracture requiring an operation with bone grafting or metallic fixation at point of fracture, the maximum will be twice the amount for the corresponding simple fracture.

OSTEOMYELITIS

Osteomyelitis requiring:	
Cutting operation for removal of bone other than simple curettement of infected area, bones of skull, spine, pelvis, femur, leg, humerus, forearm	$125.00
Bones of tarsus, carpus, hand or foot	$ 50.00
Simple incision including curettement of bones for bone infection	$ 50.00

MISCELLANEOUS

Suturing surface wound	$ 25.00
Blood transfusion--plasma	$ 50.00
Incision for drainage of superficial infections	$ 25.00

HEAD

Cutting into cranial cavity	$325.00
Reduction of fracture of maxilla (upper or lower)	$ 50.00
requiring wiring of teeth or bone	$125.00

EYES

Operation for detached retina	$325.00
Removal or evisceration of both eyes	$325.00
Removal or evisceration of one eye	$150.00
Removal or foreign body from eye or eyelid	$ 25.00

NOSE

Reduction of fracture of nasal bones	$ 50.00

NECK

Tracheotomy	$ 75.00

CHEST

Complete pneumonectomy, lobectomy	$325.00
Bronchoscopy	$100.00
Aspiration--artificial pneumothorax	$ 50.00
Reduction of fracture of one or more ribs	$ 50.00

ABDOMEN

Gastrectomy, entero-enterostomy, splenectomy	$250.00
Intestinal resection	$250.00
Colostomy, closure of perforations	$250.00
Laparotomy	$250.00
Repair of hernia, single	$150.00
double	$250.00
Gastroscopy	$ 75.00
Paracentesis of abdomen	$ 50.00

Russell 0156

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT EMERGENCY TREATMENT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

EMERGENCY TREATMENT BENEFIT

If Injury results in a Covered Family Member receiving Emergency Treatment in a Hospital Emergency Room, we will pay two times the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will only pay this benefit once for a Covered Family Member for any one Injury.

If Injury results in a Covered Family Member receiving Emergency Treatment in an Acute Care Facility, we will pay the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will pay this benefit once for a Covered Family Member for any one Injury. Treatment in an Acute Care Facility is subject to a maximum of two emergency visits per calendar year for each Covered Family Member.

X-RAY BENEFIT: If the Emergency Treatment for a covered Injury includes X-rays required by a Physician, we will pay an X-Ray Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will only pay this benefit once for a Covered Family Member for any one Injury.

CAST, SPLINT OR CRUTCHES BENEFIT: If the Covered Family Member receiving Emergency Treatment requires a cast, splint or crutches as the result of a covered Injury, we will pay a Cast, Splint or Crutches Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will pay this benefit only once, for only one of these requirements, for any one Injury. Such cast, splint or crutches must be recommended by a Physician and thereafter applied in the Hospital Emergency Room or Acute Care Facility.

AMBULANCE BENEFIT: If as a result of a covered Injury, a Covered Family Member requires transportation in an ambulance to or from a Hospital, we will pay an Ambulance Benefit equal to two times the Emergency Treatment Benefit amount shown in the Policy Schedule, for up to two trips for any one Injury.

DEFINITIONS

ACUTE CARE FACILITY means a facility providing care to patients who are not medically stable and who require frequent monitoring by health care professionals. This does not include the office of a private Physician.

ANY ONE INJURY when used in this Rider means losses incurred or medical treatment required arising out of the same accident.

CAST/SPLINT means a temporary device used to prevent motion of a joint or of the end of a fractured or broken bone. A cast/splint does not mean a brace.

CRUTCH means a support used under the armpits as an aid in walking. A crutch does not mean a cane, walker, wheelchair or other mobility device.

EMERGENCY TREATMENT means medical care for a covered Injury provided by a Physician within 72 hours of the time of the accident.

HOSPITAL EMERGENCY ROOM means a duly accredited facility set aside as such in a Hospital.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Rider effective date, only fraudulent misstatements made by you in the application for this Rider shall be used to void the Rider or to deny a claim for loss incurred commencing after the expiration of such two-year period.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement.If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Injury sustained after the date of reinstatement, subject to any provisions endorsed on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser — Secretary

William E. Wehner — President

PR-1946 Ed. 11.96

Russell 0158

08-09-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 7

MIKE RUSSELL
1469 DOGWOOD RD
W. COLUMBIA SC 29172

IMPORTANT
1. Print Clearly & answer all questions.
2. If you need additional room to complete a question, attach a sheet of paper.
3. SIGN BOTTOM OF FORM

AUGUST 14, 2008

CLAIMANT'S NAME: Michael C. Russell Soc.Sec.Num: [redacted]

Date of Birth: [redacted] Home Phone: 803-955-0389 Work Phone: 803-513-0575

Are you receiving or applying for Worker's Compensation, Unemployment Compensation or other Disability benefits? YES____NO ✓ ? If YES, please provide the name and address of the company(ies) and the policy number(s).

Employer Name: MCR Construction LLC Employer Address: 1469 Dogwood Rd. West Columbia SC 29172

Occupation: Owner of Company-Construction Monthly Gross Earnings: $ 4300

Job Duties: Owner, Vinyl Siding application.

Were you working before you became disabled? YES ✓ NO____ If NO, what were you doing?

If you are self-employed, is your business still operating? YES ✓ NO____ If NO, when did it stop?

When did you first receive medical treatment? 6-18-08 Where? Lexington Medical Center

What is the name and address of the doctor treating you? Dr. Taquino 3 Medical Park Columbia, SC 29203

What is the name and address of any other doctors you have been referred to?

What is the name and address of your primary/family physician? Dr. Vogel 5535 Platt Springs Rd. Lexington SC 29073

If you were in the hospital, please give dates of confinement: Admitted 6-18-08 Discharged 7-1-08

Hospital: Lexington Medical Center Address: 3720 Sunset Blvd West Columbia SC 29169
3 Medical Park Columbia SC 29203
(Note: a copy of hospital bill with this form)

Describe the sickness or injury Compound leg fracture, broken hip

If this is for a sickness condition, when did it first begin?

If this is an accident, when and where did it happen? Date: 6-18-08 Time: 9:20 PM Place: I-26 Exit 115

Describe how it happened: Motorcycle Accident

IF THIS IS A MOTOR VEHICLE ACCIDENT, PLEASE INCLUDE A COPY OF THE POLICE REPORT.

Have you ever had a similar condition in the past? YES____NO ✓ If YES, please give dates, a brief description and the name and address of the doctor who treated you.

IF EMPLOYED, did the condition above cause you to lose any time from work? YES ✓ NO____ If YES, provide dates.

First Day not worked 6-19-08 What duties were you unable to do? all

When were you able to do SOME of your duties? Date:_____ ALL of your duties? Date:_____

IF RETIRED, A HOUSEWIFE, STUDENT OR UNEMPLOYED, did the above condition prevent you from doing your normal daily activities? YES____NO____ If YES, provide dates. First Day unable to do activities

What activities were you unable to do?

When were you able to do SOME of your normal activities?

When were you able to do ALL of your normal activities?

Did this condition cause you to be confined? YES____NO ✓ If YES, provide dates. FROM_____ TO_____
Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Pennsylvania Life Insurance Company - PO Box 12355, Pensacola, FL 32591-2355
CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE - any medical professional, medical care institution, consumer reporting agency insurance institution, insurance support organization, institution source, governmental agency including, but not limited to, the Social Security Administration and the Veterans Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agency or legal representative, and any insurance support organization and consumer reporting agency acting on The Company's behalf, with any and all medical records and personal information, requested about me or any of my minor children.
I UNDERSTAND that this Authorization will be used to obtain, information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use OT drugs or alcohol. I UNDERSTAND the information obtained by the use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy. I KNOW that I or my legal representative may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I UNDERSTAND that the duration of this Authorization is for: This term of coverage of the policy under which a claim for benefits has been submitted. If this Authorization is given in connection with a claim for disability or life insurance benefits, I UNDERSTAND that is valid for the duration of the claim.

Mike Russell 8-27-08
SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE 10S2C

PLIC 0001

DEFENDANT'S EXHIBIT 15

Attending Physician's Report

PATIENT'S NAME: Richard Russell DOB:

1. DIAGNOSIS: (Please provide ICD Code) Primary 805.0 Secondary 883.30

2. Describe any other disease or infirmity affecting the present condition.	
3. When did symptoms first appear or accident happen?	DATE: 6-18-08
4. If accident, please describe.	motorcycle accident
5. When did this patient first consult you for this condition?	DATE: 6-18-08 TIME ____ AM ____ PM
6. Has patient ever had same or similar conditions? If YES, please state when and describe	Yes ____ No ✓
7. Please provide the name(s) and address(es) of any other treating physician(s)	
8. Provide the CPT code and date of any surgeries performed.	CPT CODE: 27759 DATE: 6-24-08 CPT CODE: 27226 DATE: 6-24-08
9. a. If hospitalized, give name and address of hospital & admission & discharge dates.	Hospital: Palmetto Richland Memorial Address: 5 Medical Plz. Dr. City: Columbia State: SC Admitted: 6-20-08 Discharged: 7-1-08
b. If confined to a nursing facility, give name and address of the facility and admission and discharge dates.	Nursing Facility: ____ Address: ____ City: ____ State: ____ Admitted: ____ Discharged: ____
10. Provide dates of treatment	Office: 7/15/08, 8/11/08 Hospital: 6-20-08 - 7-01-08 Nursing Facility: ____
11. Is patient still under your care for this condition? If NO, give the date discharged from your care.	YES ✓ NO ____ DATE: ____
12. How long was (or will) the patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	FROM: W.J. date TO: undetermined
13. How long was (or will) the patient (be) partially disabled (able to perform some but not all of his/her occupational duties)?	FROM: ____ TO: same as above
14. If retired, housewife, student or other non-employed, please indicate a reasonable period of recovery.	No activities FROM ____ TO ____ Partial activities FROM ____ TO ____
15. Was house confinement necessary? If YES, give dates. (see definition of "confinement" below)	YES ____ NO ✓ FROM ____ TO ____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

REMARKS

Name of Physician: (please print) John Iaquinto

Address: 3 Med. Plz. Dr, Ste. 330

City: Columbia

State: SC Zip: 29203

Signature: [signature]

Date: 6/27/08 Tax ID #: 582296653

Telephone #: 803-434-6458

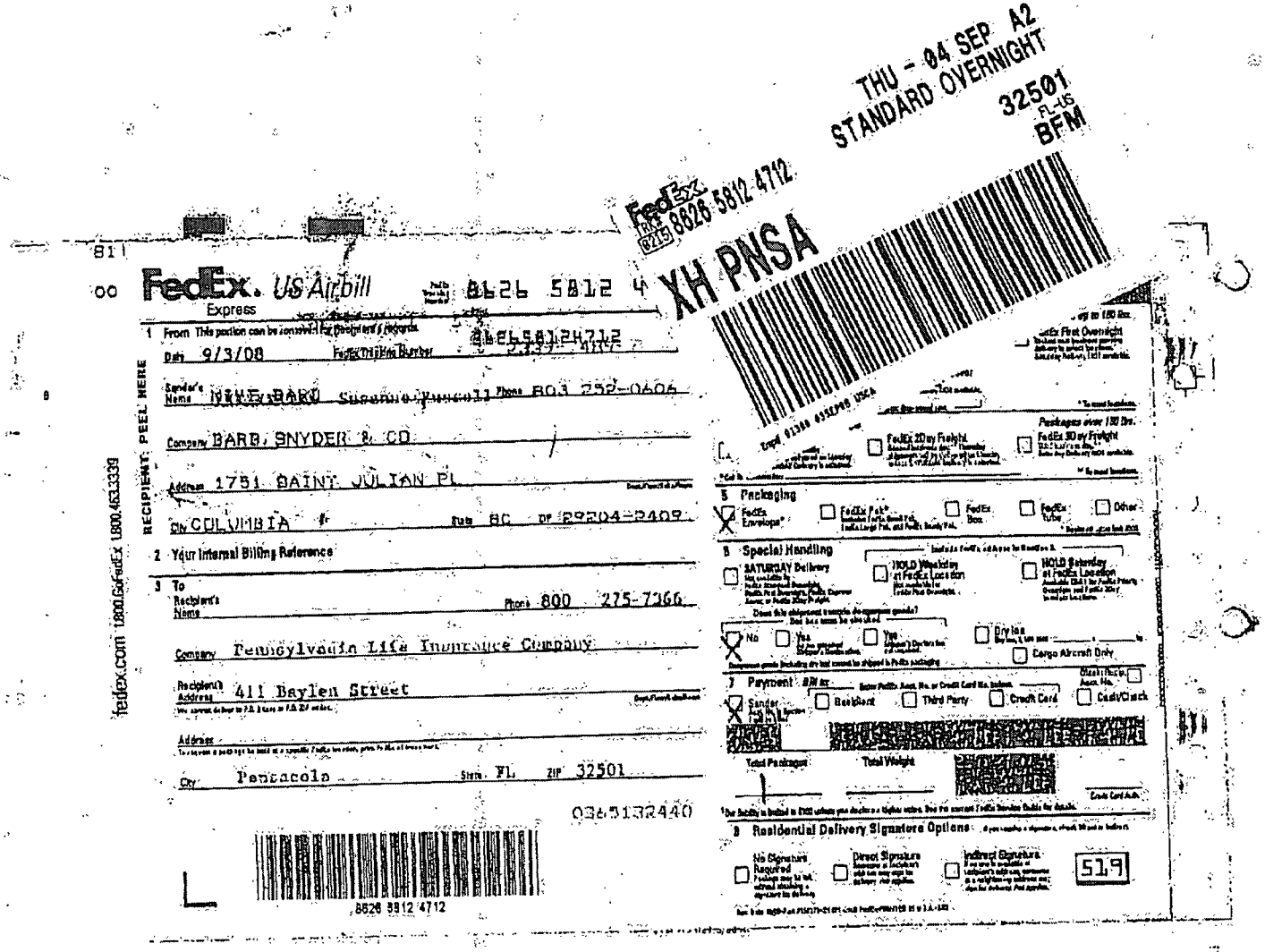
Fax #: 803-434-8537

THANK YOU – Your time is appreciated

Pennsylvania Life Insurance Company P. O. Box 12355, Pensacola, FL 32591-2355

1052C

PLIC 0002



FedEx. US Airbill Express 8626 5812 4

1 From This portion can be removed for Recipient's records. 8626581247 12

Date 9/3/08 From (Printing Starts Here)

Sender's Name MIKE BARO Phone 803 252-0404

Company BARR, SNYDER & CO

Address 1751 SAINT JULIAN PL

City COLUMBIA State SC ZIP 29204-2409

2 Your Internal Billing Reference

3 To

Recipient's Name Phone 800 275-7366

Company Pennsylvania Life Insurance Company

Recipient's Address 411 Baylen Street

Address

City Pensacola State FL ZIP 32501

0365132440

8626 5812 4712

RECIPIENT: PEEL HERE

fedex.com 1.800.GoFedEx 1.800.463.3339

THU - 04 SEP A2
STANDARD OVERNIGHT
32501
FL-US
BFM

FedEx Trk # 8626 5812 4712

XH PNSA

5 Packaging

FedEx Envelope* FedEx Pak* FedEx Box FedEx Tube Other

6 Special Handling

SATURDAY Delivery HOLD Weekday at FedEx Location HOLD Saturday at FedEx Location

No Yes Yes Dry Ice Cargo Aircraft Only

7 Payment

Sender Recipient Third Party Credit Card Cash/Check

Total Packages Total Weight

8 Residential Delivery Signature Options

No Signature Required Direct Signature Indirect Signature

519

PENNSYLVANIA LIFE INSURANCE COMPANY 06-278
BANK OF AMERICA ORLANDO, FLORIDA 611

09-22-08 00310325689

CLAIM NO: 0809-00062 POLICY: [redacted]9360

$8,125.00

EIGHT THOUSAND ONE HUNDRED TWENTY-FIVEDOLLARS AND 00 CENTS

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

CO

[redacted]

PLEASE RETAIN THIS VOUCHER AS YOUR PAYMENT RECORD

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-22-08
DEPENDENT- CLAIM NO. 0809-00062 CHECK NO. BD310325689

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1904 00	SURGICAL BENEFIT	06-24-08	06-24-08			600.00
1901 70	TOTAL DISABILITY	06-25-08	08-25-08	2MO	2000M	4,000.00
	TOTAL DISABILITY	06-25-08	08-25-08	2MO	500M	1,000.00
1904 00	SURGICAL BENEFIT	06-24-08	06-24-08			2,400.00
1946 00	AMBULANCE	06-18-08	06-18-08			50.00
	X-RAY	06-18-08	06-18-08			25.00
	EMERGENCY FIRST AID	06-18-08	06-18-08			50.00
				TOTAL THIS PAYMENT		8,125.00
				TOTAL PAID TO DATE		8,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0005

PENNSYLVANIA LIFE INSURANCE COMPANY

BANK OF AMERICA ORLANDO, FLORIDA

06-278
611

09-22-08 00310325689

CLAIM NO: 0809-00062 POLICY: [redacted]9360

$8,125.00

EIGHT THOUSAND ONE HUNDRED TWENTY-FIVEDOLLARS AND 00 CENTS

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

CO

[redacted]

PLEASE RETAIN THIS VOUCHER AS YOUR PAYMENT RECORD

PENNSYLVANIA LIFE INS. CO.

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-22-08
DEPENDENT- CLAIM NO. 0809-00062 CHECK NO. BD310325689

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			600.00
1901	70	TOTAL DISABILITY	06-25-08	08-25-08	2MO	2000M	4,000.00
		TOTAL DISABILITY	06-25-08	08-25-08	2MO	500M	1,000.00
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			2,400.00
1946	00	AMBULANCE	06-18-08	06-18-08			50.00
		X-RAY	06-18-08	06-18-08			25.00
		EMERGENCY FIRST AID	06-18-08	06-18-08			50.00
					TOTAL THIS PAYMENT		8,125.00
					TOTAL PAID TO DATE		8,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0362

PENNSYLVANIA LIFE INSURANCE COMPANY
ORLANDO, FLORIDA

BANK OF AMERICA

06-278
611

09-22-08 00310325689

CLAIM NO: 0809-00062 POLICY: [redacted]9360

$8,125.00

EIGHT THOUSAND ONE HUNDRED TWENTY-FIVEDOLLARS AND 00 CENTS

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

CO

[redacted]

PLEASE RETAIN THIS VOUCHER AS YOUR PAYMENT RECORD

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-22-08
DEPENDENT- CLAIM NO. 0809-00062 CHECK NO. BD310325689

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			600.00
1901	70	TOTAL DISABILITY	06-25-08	08-25-08	2MO	2000M	4,000.00
		TOTAL DISABILITY	06-25-08	08-25-08	2MO	500M	1,000.00
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			2,400.00
1946	00	AMBULANCE	06-18-08	06-18-08			50.00
		X-RAY	06-18-08	06-18-08			25.00
		EMERGENCY FIRST AID	06-18-08	06-18-08			50.00
						TOTAL THIS PAYMENT	8,125.00
						TOTAL PAID TO DATE	8,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0387

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

8570

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

OCT 07 2008

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	Work	803-613-0575		

1. Describe the conditions causing your disability.	motorcycle car accident - broken leg and broken pelvis
2. What is the name and address of all physicians currently treating you?	John Taquino - Premier Orthopedic Specialists 3 Highland Medical Park Dr, Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	office visit 9-22-08
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since.

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, completing puzzles etc.

DATE: 10-3-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0006

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	S/P ① acetabulum fx, grade 3A open ② tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9/22/08
3a. Next Appointment Date: 11.3.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? ~~5 9 08~~	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NO	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 10/2/08 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803-434-6958
Columbia, SC 29203

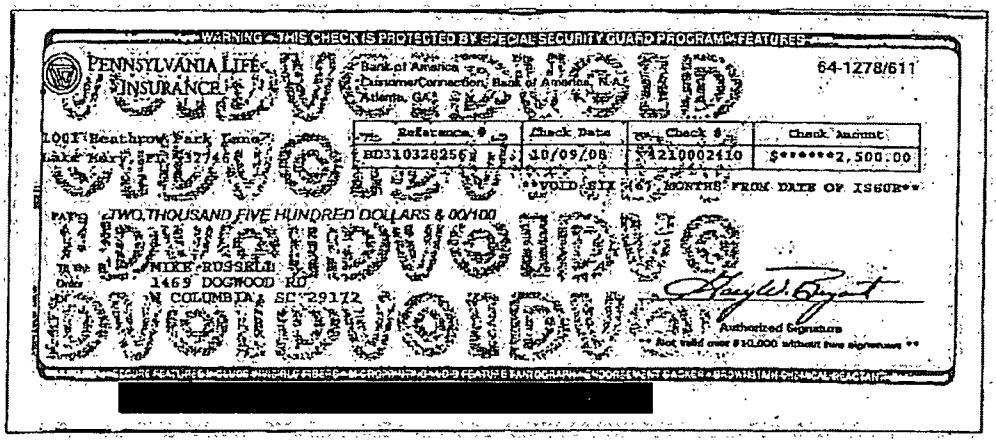
C-3 R Rev. 3-96

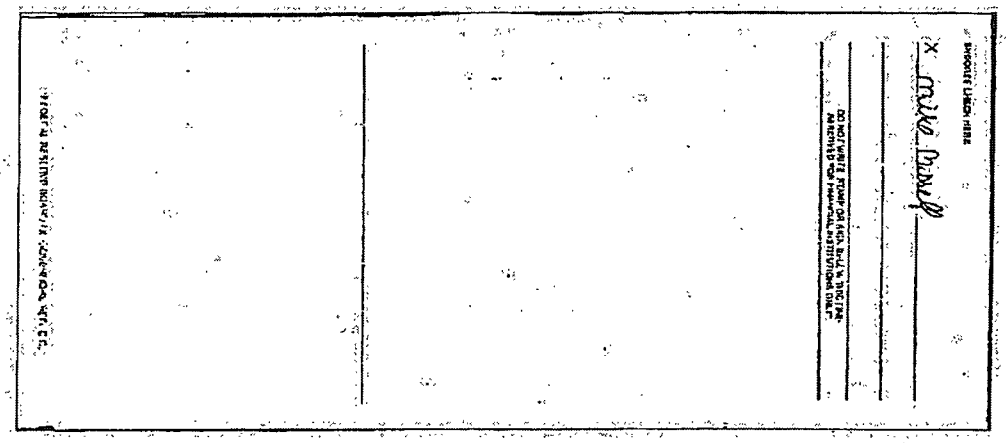
PLIC 0007

Russell
1469 Dogwood Rd.
West Columbia, SC 29170

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355





Location	Acct #	Check #	Amount	Paid Date	Sequence	Customer Data
CD	[redacted]	4210002410	$2,500.00	10/20/2008	3194484695	

R/T Number	CD VolID/CIMS Key	CD Label	Payee Name
6111278	08110340222101	08110340222101	

PLIC 0009

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

8090

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

OCT 07 2008

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	~~Cell~~ Work	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg and broken pelvis

2. What is the name and address of all physicians currently treating you?
   John Iaquinto - Premier Orthopedic Specialists
   3 Richland medical Park Dr, Suite 330
   Columbia, SC 29203

3. On what dates were you treated since completing your last report?
   office visit 9-22-08

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing physical therapy exercises, reading, completing puzzles, etc.

DATE: 10-3-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0359

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	S/P ① acetabulum fx, grade 3A open ② tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9/22/08
3a Next Appointment Date: 11.3.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES" give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? UNDETERMINED	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NO	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 10/2/08 SIGNED:

ADDRESS: 3 Medical Plz. Dr. Ste. 330 Columbia SC 29203 TELEPHONE 803.434.6958

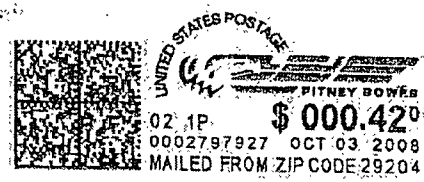
C-3 R

Rev. 3-96

PLIC 0360

ROA 720

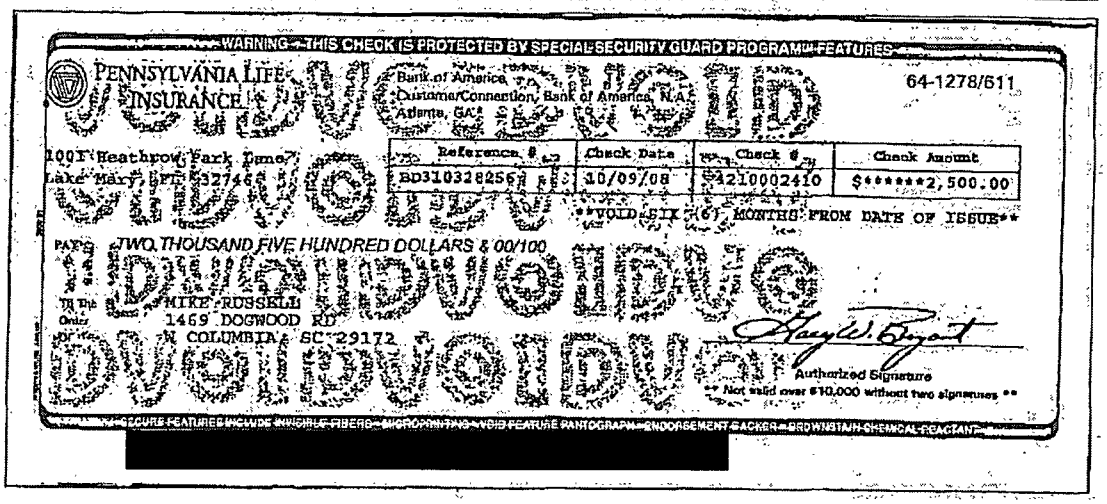
Russell
1469 Dogwood Rd.
West Columbia, SC 29170

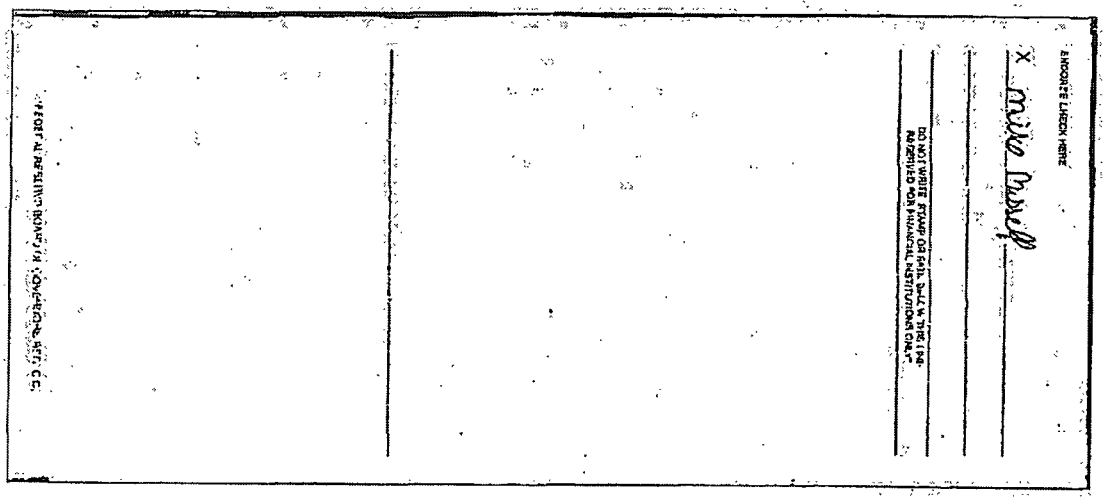


PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0361





Location	Acct #	Check #	Amount	Paid Date	Sequence	Customer Data
CD	[redacted]	4210002410	$2,500.00	10/20/2008	31944484695	

R/T Number	CD VoID/CIMS Key	CD Label	Payee Name
6111278	08110340222101	08110340222101	

(w) 858-0000 (wife)

8042

PENNSYLVANIA LIFE INSURANCE COMPANY
3 MEDICAL PARK 2ND FLOOR P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
NOV 12 2008

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name: PENSACOLA

CLAIMANT'S REPORT

Telephone Number	Home: 803-955-0329	Age:	Claim No: 02-001-001-080900052
	Cell: ~~Work~~ 803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken left hip

2. What is the name and address of all physicians currently treating you?
   John Taglione - Premier Orthopedic Specialists Briarwood Medical Park Dr. Suite 330 Columbia, SC 29203

3. On what dates were you treated since completing your last report?
   office visit 11-3-08

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital: _____
   Address: _____
   Admitted: _____ Discharged: _____

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities: _____
   Date these duties first performed: _____

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
pushing, working TV, completing physical therapy exercises, reading, etc.

DATE: 11-3-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

P-3-B Rev. 4-97

PLIC 0010

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code: 808.0, 823.30	9p ⓛ acetabulum fx, grade 3A open ⓒ tibia fx
2. Describe any other conditions contributing to present disability:	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9-22-08, 11-3-08
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? UNDETERMINED	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NOT sure of dates	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11/6/08 SIGNED:

ADDRESS: PREMIER ORTHOPEDIC SPECIALISTS
3 MEDICAL PARK, SUITE 330
COLUMBIA, SC 29203

TELEPHONE 803-434-0958

PLIC 0011

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797827 NOV 10 2006
MAILED FROM ZIP CODE 32504

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

PLIC 0012

ROA 724

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310331298	11/14/08	4210005455	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210005455
CHECK DATE 11/14/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-14-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310331298

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70 TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		13,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0013

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310331298	11/14/08	4210005455	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of: MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210005455
CHECK DATE 11/14/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-14-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310331298

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MD	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	13,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0346

(20) 252-0002 (wife)

8050

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
NOV 12 2008
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	~~Work~~	803-513-0575		

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you?	John Taquino - Premier Orthopedic Specialists Richland medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	office visit 11-3-08
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 11-3-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

Rev. 4-97

PLIC 0349

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code: 808.0, 823.30	Sp ⓛ acetabulum fx, grade 3A open ⓒ tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9-22-08, 11-3-08
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? UNDETERMINED	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NOT SURE OF DATES	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11/6/08 SIGNED:

ADDRESS: PREMIER ORTHOPEDIC SPECIALISTS
3 MEDICAL PARK, SUITE 330
COLUMBIA, SC 29203

TELEPHONE 803-434-0958

PLIC 0350

ROA 729

Russell
14169 Dogwood Bd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 NOV 10 2008
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

PLIC 0351

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1276/611

Reference #	Check Date	Check #	Check Amount
BD310331298	11/14/08	4210005455	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210005455
CHECK DATE 11/14/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-14-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310331298

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	13,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0385

320-0000 8096

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
DEC 17 2008
PENSACOLA

NIKE RUSSELL
~~1469 DOGWOOD RD~~
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	~~Work~~	803-513-0575		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you?
   John Iaquinto - Premier Orthopedic Specialists 3 Richland Medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?
   11-3-08
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 12-9-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-87

PLIC 0014

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Diagnosis: Acetabulum posterior wall fx/dislocate open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address: Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined as above
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	X YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 12/10/08 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803-434-6458
Columbia SC 29203

PLIC 0015

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 DEC 12 2008
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355 B012

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT

POLICY NO. [redacted]9360 DATE PAID 12-23-08
CLAIM NO. 0809-00062 REF ID. BD310334348

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-08	11-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-08	11-25-08	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		15,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0017

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO.

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 12-23-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310334348

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-08	11-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-08	11-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	15,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0309

300-0000

8098

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 17 2008

PENSACOLA

MIKE RUSSELL
~~1469 DOGWOOD RD~~
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you?	John Iaquinto - Premier Orthopedic Specialists 3 Richland Medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	11-3-08
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 12-9-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0338

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Acetabulum posterior wall fx/dislocation; open Otibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a. Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	undetermined as above
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[X] YES [ ] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

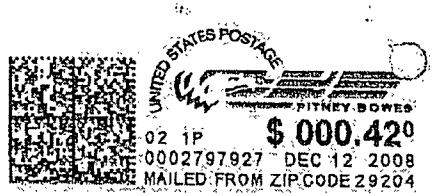
Must be furnished under authority of the law

DATE: 12/10/08 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803-434-6958
Columbia S.C. 29203

PLIC 0339

Russell
1469 Dogwood Rd.
West Columbia, SC 29172



PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

ROA 738

PLIC 0340

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 12-23-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310334348

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-08	11-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-08	11-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	15,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0384

01-28-09; 03:48PM;

8098

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	Work	803-513-0525		

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Joquinto - Premier Ortho, 3 Richland medical Park Dr. Suite 330 Cola, SC 29203
Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
11-3-08 Dr. Joquinto
12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

RECEIVED
JAN 28 2009
DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: SIGNED:

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0018

01-28-09;03:48PM;

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2356

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Acetabulum posterior wall fx/dislocat; open tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11-3-08
3a. Next Appointment Date: 2-23-08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: Address: Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/29/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr Ste. 330 TELEPHONE 803-434-6458

Columbia SC 29203

C-3 R

Rev. 3-96

PLIC 0019

Attn: Claims

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

FEB 04 2009

PENSACOLA

RECEIVED

FEB 04 2009

PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-08090[illegible]82 Policy No [redacted]9360
	Cell			
	Work	803-513-0525		

1. Describe the conditions causing your disability: motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Orthopedic Medical Park Dr. Suite 330 Colq SC 29203 — Dr. William Odom - Advanced Pain Therapies 7981 Blood River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report? 11-3-08 Dr. Iaquinto; 12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital: _____
Address: _____
Admitted: _____ Discharged: _____

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities: _____
Date these duties first performed: _____

7. When do you expect to begin working at all of your duties? Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 1-28-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0020

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Acetabulum posterior wall fx/dislocation Open tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[X] YES [ ] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/29/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803 434 6558
Columbia, SC

PLIC 0021

Russell
1409 Dogwood Rd.
West Columbia, SC 29170

COLUMBIA SC 292
29 JAN 2009 PM 1 T

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
Customer Connection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #.	Check Date	Check #	Check Amount
BD310339762	02/11/09	4210013923	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY FIVE THOUSAND DOLLARS & 00/100

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210013923
CHECK DATE 02/11/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 02-11-09
CLAIM NO. 0809-00062 REF ID. BD310339762

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-08	01-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-08	01-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		20,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0023

01-28-09;03:48PM;

Attn: Claire

8090

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home:	803-955-0329	Age: 30	Claim No: 02-001-001-080900062
	Cell:			Policy No: [redacted]9360
	Work:	803-513-0525		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Iaquinto- Premier Orthopedic & Physical Therapy, 3 Richland Medical Park Dr. Suite 330 Cola, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7921 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital _____
   Address _____
   Admitted: _____ Discharged _____

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities: _____
   Date these duties first performed: _____

7. When do you expect to begin working at all of your duties?
   unknown

RECEIVED
JAN 28 2009
DISABILITY CLAIMS

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, Completing physical therapy exercises, reading, etc.

DATE: _____ SIGNED: _____

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0262

01-28-09; 03:48PM;

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Bicetabulum posterior wall fx/dislocation Open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11-3-08
3a Next Appointment Date: 2-23-08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Undetermined
6. When did or will your patient be able to resume full work?	Undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE 1/28/09 SIGNED

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803-434-6958
Columbia, SC 29203

C-3 R Rev. 3-96

PLIC 0263

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310339762	02/11/09	4210013923	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures. **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210013923
CHECK DATE 02/11/09

PENNSYLVANIA LIFE INS CO

INSURED MIKE RUSSELL
DEPENDENT

POLICY NO. [redacted]9360 DATE PAID 02-11-09
CLAIM NO. 0809-00062 REF ID. BD310339762

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-08	01-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-08	01-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	20,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0299

Attn: Claims

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

FEB 04 2009

PENSACOLA

RECEIVED

FEB 04 2009

PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-08090082
	Cell ~~Work~~	803-513-0575		Policy No: [redacted] 9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Ortho. 3 Richland medical Park Dr. Suite 330 Cola, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? no
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 1-28-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0300

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	(L) acetabulum posterior wall fx/dislocation (L) tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a. Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: Address: Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION:

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/29/09 SIGNED:

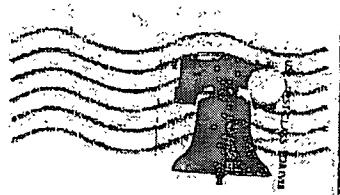
ADDRESS: 3 Medical Pk. Dr. Ste. 330 Columbia, SC TELEPHONE 803 434 6958

PLIC 0301

ROA 751

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

COLUMBIA SC 292
29 JAN 2009 PM 1 T



PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355

PLIC 0302

01-28-09;03:48PM;

Attn: Tila Lee

1/ 2

8090

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-080900052
	Cell			Policy No [redacted]9360
	Work	803-513-0575		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg, hip

2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Ortho, 3 Richland medical Park Dr. Ste 330 Col, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

RECEIVED
JAN 28 2009
DISABILITY CLAIMS

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: SIGNED:

ADDRESS:

C-3 R. Rev. 4-97

PLIC 0311

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	① Acetabulum posterior wall fx/dislocation ② tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11-3-08
3a Next Appointment Date: 2-23-08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/28/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803 434. 6938
Columbia, SC 29203

C-3 R Rev. 3-96

PLIC 0312

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310339762	02/11/09	4210013923	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210013923
CHECK DATE 02/11/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]360 DATE PAID 02-11-09
DEPENDENT- CLAIM NO. 0809-00062 REP ID. BD310339762

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-08	01-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-08	01-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		20,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0383

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

MAR 13 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age:	Claim No: 02-001-001-080900062
	Cell / ~~Work~~	803-513-0575	36	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg - hip

2. What is the name and address of all physicians currently treating you? John Faquino
Palmetto Medical Park Ste 330 Columbia, SC 29203

Dr. William Odom
PO Box 1997
Elmo, SC 29063

3. On what dates were you treated since completing your last report?

Dr. Odom - Jan 19th, March
Dr Faquino Feb [redacted]8

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)

Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?

☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.

Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?

unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)

☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading etc.

DATE: 3-10-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia SC 29172

C-3 R

Rev. 4-97

PLIC 0024

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability. Degenerative Disease	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 3/2/09
3a Next Appointment Date: April 1, 2009	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address
	Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 3/2/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE: 803-749-8585

PLIC 0025

Russell
1469 Dogwood Rd.
West Columbia SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 MAR 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

PLIC-0026

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310342678	03/16/09	4210016833	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100

To the Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 42100168
CHECK DATE 03/16/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 03-16-09
CLAIM NO. 0809-00062 REF ID- BD310342678

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70 TOTAL DISABILITY	01-25-09	02-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-09	02-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		23,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0027

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310342678	03/16/09	4210016833	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To the Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210016833
CHECK DATE 03/16/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 03-16-09
CLAIM NO. 0809-00062 REF ID. BD310342678

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-09	02-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-09	02-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	23,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0256

PENNSYLVANIA LIFE INSURANCE COMPANY

P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 13 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC
29172

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

RECEIVED
MAR 13 2009
PENSACOLA DISABILITY CLAIMS

2. What is the name and address of all physicians currently treating you? John Iaquinto
   3 Richland Medical Park Sc 1330 Columbia, SC 29203
   Dr. William Odom
   PO Box 1997
   Irmo, SC 29063

3. On what dates were you treated since completing your last report?
   Dr. Odom - Jan 19th, March
   Dr. Iaquinto Feb 18

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO. I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading etc.

DATE: 3-10-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia SC 29172

C-3 R Rev. 4-97

PLIC 0258

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability. Degenerative Disease	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 3/2/09
3a Next Appointment Date: April 1, 2009	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

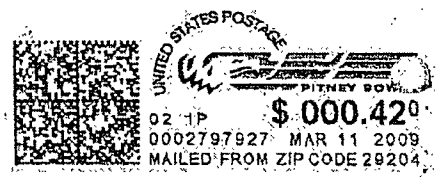
Must be furnished under authority of the law

DATE: 3/2/09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-8585

PLIC 0259

Russell
1469 Dogwood Rd.
West Columbia SC 29172



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

ROA 762

PLIC 0260

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310342678	03/16/09	4210016833	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210016833
CHECK DATE 03/16/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 03-16-09
CLAIM NO. 0809-00062 REF ID. BD310342678

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-09	02-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-09	02-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	23,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0382

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

3070

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

APR 08 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	~~Work~~ Cell	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg and hip

2. What is the name and address of all physicians currently treating you? Dr. William Odom PO Box 1997 Irmo, SC 29063
Dr. Randall Suarez - Lexington Orthopedics 146 A Hospital Drive Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - April 1
Dr. Suarez - March 17

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 4-6-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

PLIC 0028

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 726.2	
2. Describe any other conditions contributing to present disability: Degenerative DZ	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: April 1, 2009
3a. Next Appointment Date: April 29, 2009	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 4/1/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-8585

PLIC 0029

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0030

ROA 766

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310345383	04/10/09	4210019546	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210019546
CHECK DATE 04/10/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 04-10-09
CLAIM NO. 0809-00062 REF ID. BD310345383

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-09	03-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	02-25-09	03-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		25,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC.0031

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
HD310345383	04/10/09	4210019546	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210019546
CHECK DATE 04/10/09

PENNSYLVANIA LIFE INS CO

INSURED MIKE RUSSELL
DEPENDENT

POLICY NO. [redacted]9360 DATE PAID 04-10-09
CLAIM NO. 0809-00062 REF ID. HD310345383

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-09	03-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	02-25-09	03-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	25,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0251

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

APR 08 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg and hip
2. What is the name and address of all physicians currently treating you? Dr. William Odom PO Box 897 Elmo, SC 29063	Dr. Randall Suarez - Lexington Orthopedics 146 N. Hospital Drive Suite 140 West Columbia SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - April 1 Dr. Suarez - March 17
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 4-6-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

PLIC-0253

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability. Degenerative DZ	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: April 1, 2009
3a Next Appointment Date: April 29, 2009	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

[redacted]

Must be furnished under authority of the law

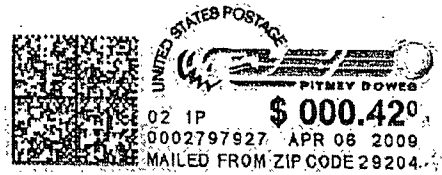
DATE: 4/1/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE: 803-749-8585

PLIC 0254

ROA 771

Russell
1469 Dogwood Rd.
West Columbia, SC 29172



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0255

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310345383	04/10/09	4210019546	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY: *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of: MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210019546
CHECK DATE 04/10/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 04-10-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310345383

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-09	03-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	02-25-09	03-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	25,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0381

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

8090

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
RECEIVED
MAY 08 2009
MAY 08 2009
PENSACOLA

Mike Russell
1469 Dogwood Road
West Columbia SC 29172

Dependent Name: [redacted] DISABILITY CLAIMS

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 0809-0002
	Cell ~~Work~~	803-513-0575		Policy No: [redacted] 9340

1. Describe the conditions causing your disability: motorcycle wreck - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Pmo, SC 29063 — Dr. Suarez + Dr. Dedmond - Lexington Orthopedic 146 D. Hospital Dr. Suite 140 West Columbia SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom - April 29 Dr. Suarez - April 21 Dr. Dedmond - April 28

4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.) — Hospital ____ Address ____ Admitted: ____ Discharged: ____

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began. — Describe work or activities: ____ Date these duties first performed: ____

7. When do you expect to begin working at all of your duties? unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.) ☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since: ____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, Completing exercises, reading, etc.

DATE: 4-29-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia SC 29172

C-3 R Rev. 4-97

PLIC 0032

PENNSYLVANIA LIFE INSURANCE COMPANY
EXECUTIVE OFFICES: P. O. Box 720, Buffalo, NY 14201-0720

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability:	
3. Describe dates of treatment since last report and indicate if patient is still under your care 4-29-09	Dates of treatment since last report: 4-29-09
3a Next Appointment Date: 5-28-09	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital NO Address Admitted: _____ Discharged _____
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 4-29-09 SIGNED: [signature]

ADDRESS: PO Box 1999 Imo, Sc TELEPHONE 803-749-8585

PLIC 0033

[redacted]
West Columbia, SC 29172

Pennsylvania Life Insurance Co.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310348278	05/20/09	4210022422	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures.**

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210022422
CHECK DATE 05/20/09

PENNSYLVANIA LIFE INS CO

INSURED MIKE RUSSELL
DEPENDENT

POLICY NO. [redacted]9360 DATE PAID 05-20-09
CLAIM NO. 0809-00062 REF ID. BD310348278

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	03-25-09	04-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	03-25-09	04-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		28,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0035

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310348278	05/20/09	4210022422	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210022422
CHECK DATE 05/20/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 05-20-09
CLAIM NO. 0809-00062 REF ID. BD310348278

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	03-25-09	04-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	03-25-09	04-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	28,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0246

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

8090

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
RECEIVED
MAY 08 2009
MAY 08 2009
PENSACOLA
DISABILITY CLAIMS

Mike Russell
1469 Dogwood Road
West Columbia, SC 29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 0809-00062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]360

1. Describe the conditions causing your disability: motorcycle wreck - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom 80 Box 1997 Pmo, SC 29063 — Dr. Suarez + Dr. Dedmond - Lexington Orthopedic 146 D. Hospital Dr. Suite 140 West Columbia SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom - April 09 Dr. Suarez - April 01 — Dr. Dedmond - April 08

4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.) — Hospital: Address: Admitted: Discharged:

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began. — Describe work or activities: Date these duties first performed:

7. When do you expect to begin working at all of your duties? unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.) ☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, completing exercises, reading, etc.

DATE: 4-29-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia SC 29172

C-3 R Rev. 4-97

PLIC 0248

PENNSYLVANIA LIFE INSURANCE COMPANY
EXECUTIVE OFFICES: P. O. Box 720, Buffalo, NY 14201-0720

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93 ; 720.2	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 4-29-09	Dates of treatment since last report: 4-29-09
3a Next Appointment Date: 5-28-09	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital NO Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 4-29-09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC TELEPHONE 803-749-8585

PLIC 0249

1101 Edgewood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 MAY 05 2009
MAILED FROM ZIP CODE 29204

Pennsylvania Life Insurance Co.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 780

PLIC 0250

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310348278	05/20/09	4210022422	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210022422
CHECK DATE 05/20/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 05-20-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310348278

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	03-25-09	04-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	03-25-09	04-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		28,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0380

8890

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
JUN 24 2009
RECEIVED
PENSACOLA
JUN 24 2009
PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	Cell / Work	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Juarez + PC Dedmond - Lexington Ortho pedics 146 A. Hospital Dr Suite 110 West Columbia SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - May 28
Dr. Dedmond - May 8 (surgery) + May 20

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
OA patient Surgery - Exchange Nailing (L) Tibia with Fibular Osteotomy
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 5-8-09 Discharged 5-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing exercises reading, etc.

DATE: 6-15-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0036

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code: 823.80	Closed Fracture Tibia
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care. 4/28/09 6/26/09 6/15/09	Dates of treatment since last report:
3a Next Appointment Date: 7-8-09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unable to tell next eval 7-8-09	
6. When did or will your patient be able to resume full work? Unable to tell next re-eval 7-8-09	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 6/15/09 SIGNED:

ADDRESS: 146 North Hospital Dr. W. Columbia SC 29169 TELEPHONE 803-936-7230

PLIC 0037

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
50809	DEDMOND MD	REPAIR TIBIA	MIKE	2,188.00		
		AMOUNT APPLIED TO DEDUCTIBLE: $619.29				
		Insurance Balance: 1,319.48		Patient Balance:		868.52
50809	DEDMOND MD	INCISION FIBULA	MIKE	947.00		
		Insurance Balance: 883.55		Patient Balance:		63.45

Statement
Date: 05/21/09

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: [redacted]

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
0.00	0.00	0.00	0.00	3,135.00	2,203.03	931.97

MAKE CHECKS PAYABLE TO:
GREENWOOD ORTHOPAEDICS
726 N HOSPITAL DR SUITE 140
WEST COLUMBIA, SC 29169
803-936-9662

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

PLIC 0038

Russell
1469 Dogwood Rd
West Columbia, SC 29172

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591x2355

PLIC 0039

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310353355	07/06/09	4210027524	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210027524
CHECK DATE 07/06/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-06-09
CLAIM NO: 08D9-00062 REF ID. BD310353355

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	04-25-09	05-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	04-25-09	05-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	30,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0040

PENNSYLVANIA LIFE INSURANCE

Bank of America.
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310353355	07/06/09	4210027524	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210027524
CHECK DATE 07/06/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO: [redacted]9360 DATE PAID 07-06-09
CLAIM NO. 0809-00062 REF ID. BD310353355

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	04-25-09	05-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	04-25-09	05-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		30,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0240

8540

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

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MAIL CENTER

JUN 24 2009

RECEIVED

PENSACOLA JUN 24 2009

PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	Cell / Work	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Juarez + Dr. Dedmond - Lexington Ortho pedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - May 28
Dr. Dedmond - May 8 (surgery) + May 26

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
Outpatient Surgery - Exchange Nailing @ Tibia with Fibular osteotomy
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 5-8-09 Discharged 5-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, completing exercises, reading, etc.

DATE: 6-15-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0242

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80	Closed Fracture Tibia
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care. 4/28/09 6/26/09 6/15/09	Dates of treatment since last report:
3a. Next Appointment Date: 7-8-09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? Unable to tell next eval 7-8-09	
6. When did or will your patient be able to resume full work? Unable to tell next re-eval 7-8-09	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 6/15/09 SIGNED:

ADDRESS: 146 North Hospital Dr. W. Col SC TELEPHONE 803-936-7230

2/9/09

PLIC 0243

ROA 790

Russell
14169 Dogwood Rd.
West Columbia, SC 29172



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591X2355

PLIC 0245

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310353355	07/06/09	4210027524	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210027524
CHECK DATE 07/06/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 07-06-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310353355

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	04-25-09	05-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	04-25-09	05-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		30,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0379

PENNSYLVANIA LIFE INSURANCE COMPANY

P.O. Box 12355, Pensacola, FL 32591-2355

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MAIL CENTER
AUG 13 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 37	Claim No: 02-001-001-080900062
	Cell			Policy No [redacted]9360
	Work	803-513-0575		

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom June 25
Dr. Dedmond July 8

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
Out patient surgery - exchange nailing (D) Tibia s/p Ender osteotomy
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 5-8-09 Discharged 5-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, walking TV, completing exercises, reading, etc.

DATE: 7-29-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0041

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80 808.0	Closed fracture unspecified fibia Acetabular Fracture
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care. 5/8/09	Dates of treatment since last report:
3a Next Appointment Date: 8/26/09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unknown	
6. When did or will your patient be able to resume full work? Unknown	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[X] YES [ ] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Pt underwent surgery on 5/8/09 for a left tibial nonunion

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law.

DATE: 7/29/09 SIGNED:

ADDRESS: 146 N. Hospital Dr. W. Columbia, SC 29169 TELEPHONE 803-936-7230

PLIC 0042

YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs. We have received your payment. Please pay the balance in full or contact Customer Service for any questions regarding this bill.

10Z37-P555

SUMMARY OF CHARGES

250 PHARMACY GENERAL	582.00
258 PHARMACY IV SOLUTIONS	136.00
259 PHARMACY OTHER	10.25
270 MS SUPPLY GENERAL	618.50
272 MS SUPPLY STERILE SUPPLY	5866.21
278 MS OTHER IMPLANTS	27716.50
300 LABORATORY GENERAL	13.00
301 LABORATORY IMMUNOLOGY	90.00
305 LAB HEMATOLOGY	226.00
306 LAB BACTERIOLOGY/MICROBIO	336.00
312 LAB PATHOLOGY/HISTOLOGY	22.00
320 RADIOLOGY DIAG GENERAL	925.00
350 DE SVCS GENERAL	1023.00
370 ANESTHESIA GENERAL	1392.00
636 DRUGS SPEC TO DETAIL CODING	32.00
710 RECOVERY ROOM GENERAL	1210.00
981 PROF FEES ANESTHETISTS RNA	6806.00
Billed charges to date:	51303.96



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

PAGE: 1 of 1

0101

MICHAEL C RUSSELL
1469 DOGWOOD ST
WEST COLUMBIA, SC 29172-2451

[redacted]

INSURANCE INFORMATION

BLUE CHOICE/COMPASSION 2Q1302411197

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST?
CALL CUSTOMER SERVICE REPRESENTATIVE AT
(803) 732-2273 OR (877) 888-2275, MONDAY-FRIDAY,
8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	06/25/09
Patient Name:	MICHAEL C RUSSELL
Date of Service:	05/08/09
Account Number:	[redacted]
Total Charges:	51303.96
Insurance Payments Received:	39041.91
Adjustments to Charges:	10993.55
Patient Payments Received:	35.00
This is your balance:	2483.42

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
07/10/2009	06/25/09	[redacted]

AMOUNT DUE	SHOW AMOUNT PAID HERE
2483.42	$

651741E

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*TONO,J8BU0001149

[redacted]

PLIC 0043

Russell
1409 Dogwood Rd.
West Columbia SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002787927 AUG 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 795

PLIC 0044

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY FIVE THOUSAND DOLLARS & 00/100

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED: MIKE RUSSELL
DEPENDENT:
POLICY NO. [redacted]9360 DATE PAID 09-08-09
CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0045

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-08-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0175

0040

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
AUG 13 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	Work	803-513-0575		

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom June 25 Dr. Dedmond July 8
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.) Out patient Surgery - exchange nailing ⓛ Tibia w/ Fibular osteotomy	Hospital Lexington Medical Center Address West Columbia, SC 29169 Admitted: 5-8-09 Discharged 5-8-09
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 7-29-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0182

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80 808.0	Closed fracture unspecified tibia Acetabular Fracture
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 5/8/09	Dates of treatment since last report:
3a Next Appointment Date: 8/26/09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unknown	
6. When did or will your patient be able to resume full work? Unknown	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Pt underwent surgery on 5/8/09 for a left tibial nonunion

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/09 SIGNED:

ADDRESS: 146 N. Hospital Dr. W. Columbia, SC 29170 TELEPHONE 803-936-7230

PLIC 0183

ROA 800

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 AUG 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0185

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures. **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-08-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0378

PENNSYLVANIA LIFE INSURANCE COMPANY
P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
SEP 28 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-935-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg and hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Desmond - Lexington Orthopedic 140 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - Aug. 25
Dr. Desmond + Suarez Aug. 26

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☒ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

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PENSACOLA DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☒ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc

DATE: 9-23-09 SIGNED: Mike Russell
ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0046

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80, 823.81 996.4	closed fracture of tibia closed fracture of fibula mechanical compl. of internal orthopaedic device
2. Describe any other conditions contributing to present disability: see above	
3. Describe dates of treatment since last report and indicate if patient is still under your care. yes 7/8/09 8/26/09	Dates of treatment since last report: 8/26/09, 7/8/09 &
3a. Next Appointment Date: 9/29 - Dr. Suarez 10/26/09 - Dr. Dedmond	Patient discharged on: no
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? unable to determine - re-eval on 10/26 with Dr. Dedmond - for leg surgery on 10/5/09 w/Dr. Suarez for hip	
6. When did or will your patient be able to resume full work? unable to determine	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION:

patient being treated by Dr. Barnaby Dedmond for his left tibia/fibula fracture and will be evaluated and treated by Dr. Randall Suarez for his hip.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/18/09 SIGNED: B Dedmond

ADDRESS: Lexington Orthopaedics, 146 N. Hospital Drive, Suite 140, West Columbia, SC 29169 TELEPHONE 803-936-7230

C-3 R

Rev. 3-96

PLIC 0047

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 SEP 24 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 10-09-09
CLAIM NO. 0809-00062 REF ID. BD310361735

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0064413 M/C 091477

PLIC 0049

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 10-09-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID BD310361735

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
		TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
						TOTAL THIS PAYMENT	2,500.00
						TOTAL PAID TO DATE	38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0163

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

SEP 2 8 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg and hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom, PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Redmond - Lexington Orthopedic 140 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - Aug. 25
   Dr. Redmond + Suarez Aug. 26

4. Have you been confined to a hospital since completing your last report? no
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital:
   Address:
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

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SEP 2 8 2009
PENSACOLA DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO; I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 9-23-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0165

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code: 823.80, 823.81 996.4	closed fracture of tibia closed fracture of fibula mechanical compl. of internal orthopaedic device
2. Describe any other conditions contributing to present disability: See above	
3. Describe dates of treatment since last report and indicate if patient is still under your care: 7/8/09 8/26/09 yes	Dates of treatment since last report: 7/8/09 & 8/26/09.
3a. Next Appointment Date: 9/29- Dr. Suarez 10/26/09- Dr. Dedmond	Patient discharged on: no
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? unable to determine -	re-eval on 10/26 with Dr. Dedmond - for leg surgery on 10/5/09 w/Dr. Suarez for hip
6. When did or will your patient be able to resume full work? unable to determine	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

patient being treated by Dr. Barnaby Dedmond for his left tibia/fibula fracture and will be evaluated and treated by Dr. Randall Suarez for his hip.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/18/09 SIGNED: BDell

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive
Suite 140
West Columbia, SC 29169

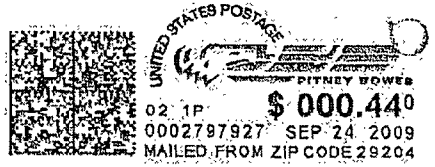
TELEPHONE 803-936-7230

C-3 R

Rev. 3-96

PLIC 0166

Russell
1469 Dogwood Rd.
West Columbia, SC 29172



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 809

PLIC 0167

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 10-09-09
CLAIM NO. 0809-00062 REF ID. BD310361735

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0377

PENNSYLVANIA LIFE INSURANCE COMPANY
P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

RECEIVED
OCT 27 2009
PENSACOLA DISABILITY CLAIMS

MAIL CENTER
OCT 27 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age	Claim No: 02-001-001-080900062
Cell	Home	803-955-0329	37	Policy No [redacted]9360
~~Cell~~	Work	803-513-0573		

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom
   PO Box 1997 Irmo, SC 29063
   Dr. Scott2 + Dr. Redmond- Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom- Aug. 25
   Dr. Redmond Aug. 26
   Dr. Scott2 Sept. 29

4. Have you been confined to a hospital since completing your last report? Yes
   (If "YES", give date of confinement and attach a copy of your hospital bill.) have not received bill yet
   Hospital: Lexington Medical Center
   Address: West Columbia, SC 29169
   Admitted: 10-5-09 Discharged: 10-8-09

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☑ YES, I have been confined to the house since completing my last report.
   ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 10-27-09 SIGNED: Mike Russell

ADDRESS: 14169 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0050

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD Code:	733.42
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09 Dr. Dalton 9/29/09 - Dr. Swartz 10/5/09 - Dr. Swartz (Surgery) 10-29-09 Swartz
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report?	Hospital: Lexington Medical Center
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address: 2720 Sunset Blvd Admitted: 10-5-09 Discharged: 10-8-09
5. When did or will your patient be able to resume some work or activity?	Approx: 1-5-10
6. When did or will your patient be able to resume full work?	Approx. 1-5-10
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[ ] YES [X] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

DATE 10-20-09 SIGNED: [signature]

ADDRESS: TELEPHONE

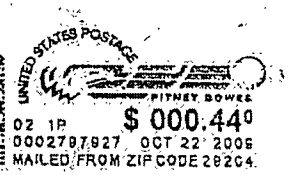
C-3-R Rev. 3-96

PLIC 0051

ROA 813

Russell
1469 Dogwood Rd.
West Columbia, SC 29172

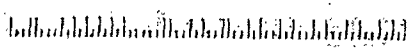






PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

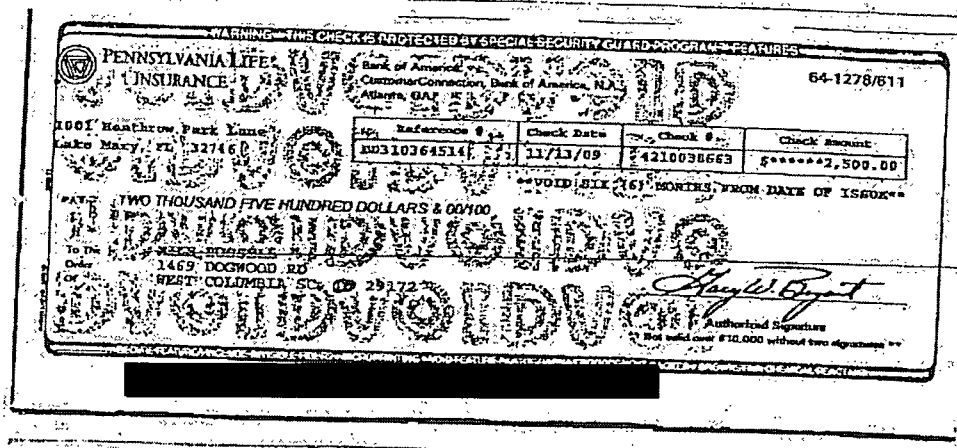
32591+2355



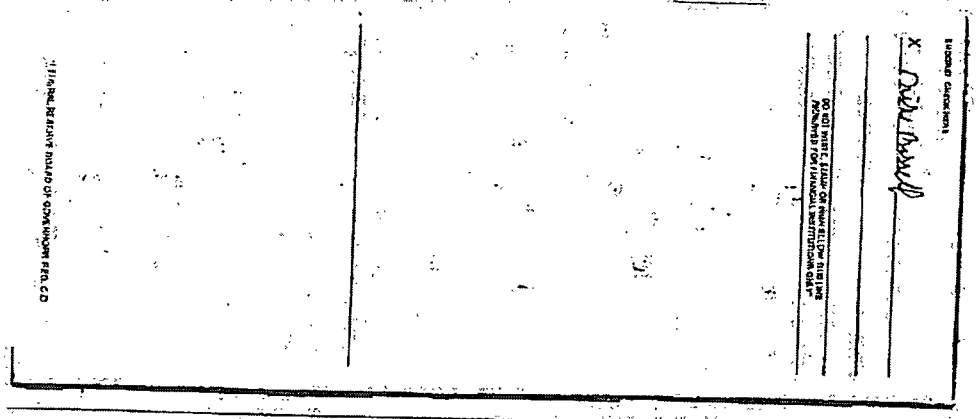
PLIC 0052

Document type : Disbursement Check

06/03/2010 12:10 PM



[redacted]



Tag	Note	Item Date	Sequence Number	Account Number
Routing Number	Amount	Serial Number	Image Indicator	Sorry Indicator
Customer Data	Payee Name	Volume ID	Account Name	Issue Date
No	No	11/20/2009	2354675855	[redacted]
6111278	2500.00	4210038663	1	0
		09120100077101		

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

RECEIVED
OCT 27 2009
PENSACOLA DISABILITY CLAIMS

MAIL CENTER
OCT 27 2009
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0309	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]360

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom- Aug. 25
   Dr. Dedmond Aug. 26
   Dr. Suarez Sept. 29

4. Have you been confined to a hospital since completing your last report? YES
   (If "YES", give date of confinement and attach a copy of your hospital bill.) have not received bill yet
   Hospital Lexington medical Center
   Address West Columbia, SC 29169
   Admitted: 10-5-09 Discharged 10-8-09

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☑ YES, I have been confined to the house since completing my last report.
   ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 10-21-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0153

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	733.42
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09 Dr. Dehmer 9/24/09 - Dr. Shaines 10/5/09 - Dr. Shaines (Surgery) 10-29-09 Shaines
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report?	Hospital: Lexington Medical Center
	Address: 2720 Sunset Blvd
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Admitted: 10-5-09 Discharged 10-8-09
5. When did or will your patient be able to resume some work or activity?	Approx 1-5-10
6. When did or will your patient be able to resume full work?	Approx 1-5-10
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION:

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

Lexington Orthopaedics
146 N. Hospital Drive, Ste 140
West Columbia, SC 29169
(803) 936-7230

DATE: 10-20-09 SIGNED: [signature]

ADDRESS: TELEPHONE

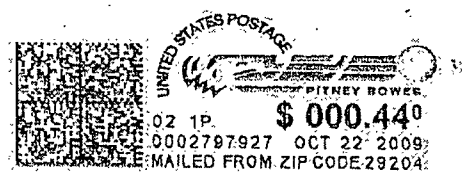
C-3 R

Rev. 3-96

PLIC 0154

ROA 817

Russell
1469 Dogwood Rd.
West Columbia, SC 29172



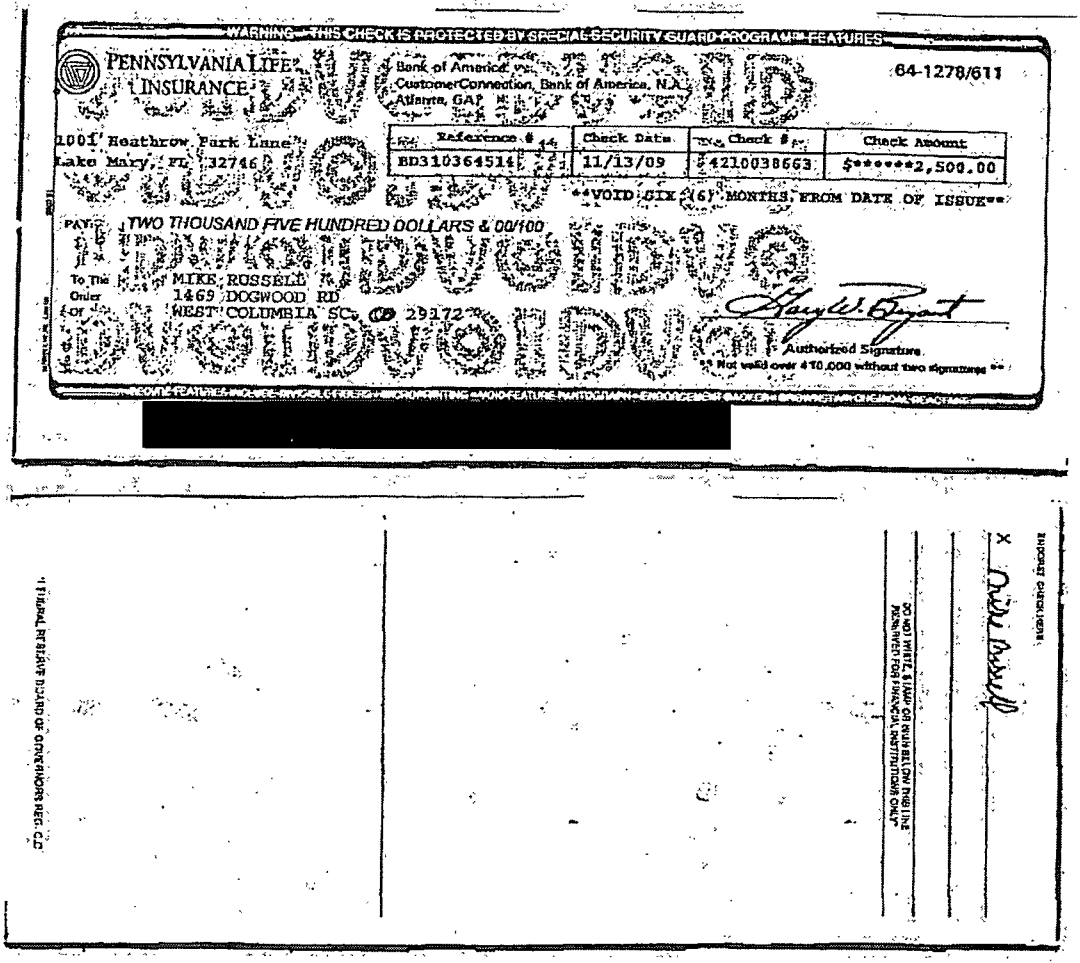
PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0155

Document type : Disbursement Check

06/03/2010 12:10 PM



Tag	Note	Item Date	Sequence Number	Account Number
Routing Number	Amount	Serial Number	Image Indicator	Sorry Indicator
Customer Data	Payee Name	Volume ID	Account Name	Issue Date
No	No	11/20/2009	2394675855	[redacted]
6111278	2500.00	4210038663	1	0
		09120100077101		

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 08 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number (Cell)	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident- broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Desmond- Lexington Ortho. 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report? Dr. Odom- Oct 26	Dr. Desmond Oct. 26 Dr. Suarez Oct. 29, Nov. 10
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☑ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 12-2-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0054

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Tib/Fib fx - rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09, 10-29-09, 11-10-09
3a Next Appointment Date:	Patient discharged on: N.D
4. Has the patient been confined to a hospital since completing your last report? N.D (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law.

DATE: 11-30-09 SIGNED: Randall S. Young, M.D.

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste 140
West Columbia, SC 29169
803) 936-7[illegible]

TELEPHONE:

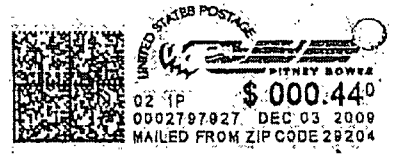
C-3 R

Rev. 3-98

PLIC 0055

ROA 821

Russell
14609 Dogwood Rd.
West Columbia SC 29172



PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0056

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 01-12-10
CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901.70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		45,625.00

PARTIAL PAYMENT

ADJ B090 STATE 38 S/C 0044413 M/C 091477

PLIC 0057

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$*****5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 01-12-10
CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	45,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0125

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 08 2009

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident- broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Desmond- Lexington Ortho. 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Desmond Oct. 26 Dr. Suarez Oct. 29, Nov. 10
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☑ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 12-2-09 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0132

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Tib/fib-fx-rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09, 10-29-09, 11-10-09
3a Next Appointment Date:	Patient discharged on: No
4. Has the patient been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec: #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11-30-09 SIGNED: Rankin S. Shirey, M.D.

ADDRESS: Lexington Orthopaedics
~~146 N. Hospital Drive, Ste 140~~
West Columbia, SC 29169
(803) 936-7[illegible]

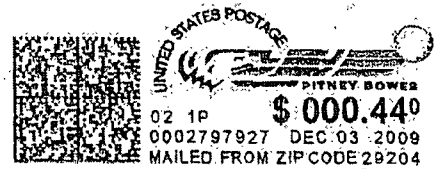
TELEPHONE

C-3 R

Rev. 3-96

PLIC 0133

Bessell
1469 Dogwood Rd.
West Columbia, SC 29172



PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 826

PLIC 0134

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 01-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	45,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0375

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
JAN 28 2010
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Cell	Home	955-0329	Age: 37	Claim No: 02-001-001-080900062
	Work	803-513-0525		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg and hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063
Dr. Suarez + Dr. Redmond - Lexington Orthopedics Lex. Co. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - 1-18-10
Dr. Suarez - 12-17-09

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, walking TV, completing exercises, reading, etc.

DATE: 1-25-10 SIGNED: Mike Russell
ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0058

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/p (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/p (L) Hip/fib rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 12-17-09
3a Next Appointment Date: 1-28-10	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other Employer I.D. #

Must be furnished under authority of the law

DATE: 1/20/10 SIGNED: Randall S Stuart, M.D.

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

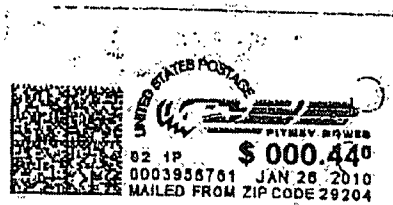
TELEPHONE

C-3-R

Rev. 3-96

PLIC 0059

1469 Dogwood Rd.
West Columbia, SC 29170



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0060

ROA 830

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS &00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 02-12-10
CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0061

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 02-12-10
CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0119

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
JAN 28 2010
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	
Call	Home	955-0329	37	Claim No: 02-001-001-080900062
	~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg and hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063	Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - 1-18-10 Dr. Suarez - 12-17-09
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 1-25-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0122

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/p (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/p (L) tib/fib rod dmg
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 12-17-09
3a Next Appointment Date: 1-28-10	Patient discharged on: —
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/20/10 SIGNED: Randall S Stucy, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

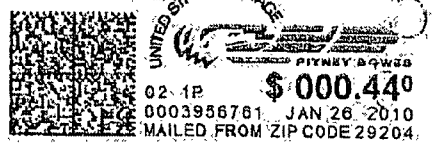
TELEPHONE

C-3 R

Rev. 3-96

PLIC 0123

1469 Dogwood Rd.
West Columbia, SC 29170



PENNSYLVANIA LIFE
INSURANCE CO.
P.O Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0124

ROA 835

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 02-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
		TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
						TOTAL THIS PAYMENT	5,000.00
						TOTAL PAID TO DATE	50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0374

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2010
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age: 37	Claim No: 00-001-001-08090062
	Cell Work	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you?	Dr. Odom PO Box 1997 Irmo, SC 29063 / Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 O. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - 1-18-10 / Dr. Suarez - 2-25-10
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: / Address: / Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: / Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 3-1-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0062

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) total h.p 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) hip/gb rod in
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 1/25/10, 2/25/10
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2-25-10 SIGNED: Randall S. Bridges, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste. 140
West Columbia, SC 29169
(803) 936-7230

TELEPHONE

C-3 R

Rev. 3-96

PLIC 0063

1469 Dogwood Rd.
West Columbia, SC 29172

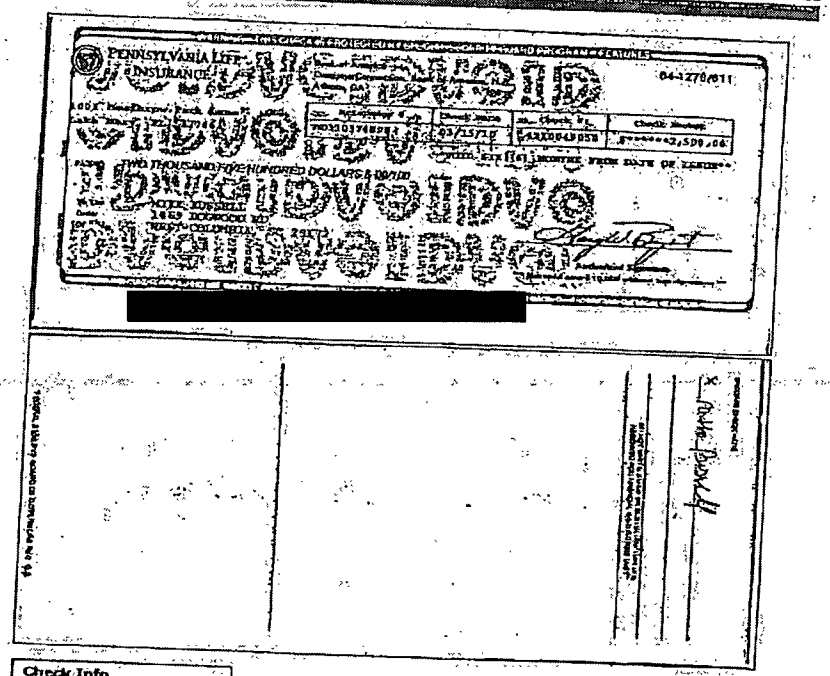
UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0003958781 MAR 01 2010
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

Bank of America Higher Standards

Bank of America Direct



Check Info	
Account:	[redacted]
Amount:	2,500.00
Check #:	4210049058
Posted Date:	03/24/2010

Bank of America, N.A. Member FDIC.
©2005 Bank of America Corporation. All rights reserved.

PLIC 0065

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2010
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home:	803-955-0389	Age: 37	Claim No: 02-001-001-0B0900062
	Cell / ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 1146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom — 1-18-10
   Dr. Suarez — 2-25-10

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 3-1-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0116

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) total h.p. 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) tib/fib rod dmi
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 1/20/10, 2/25/10
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2-25-10 SIGNED: Randall S. Burkey, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

TELEPHONE

C-3.R

Rev. 3-96

PLIC 0117

PLIC 0118

ROA 843

1469 Dogwood Rd.
West Columbia, SC 29172

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0003956761 MAR 01 2010
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

325914-2365

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310374898	03/15/10	4210049058	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL — CHECK NUMBER 4210049058
SOURCE CODE ACL — CHECK DATE 03/15/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL — POLICY NO. [redacted]9360 — DATE PAID 03-15-10
DEPENDENT- — CLAIM NO. 0809-00062 — REF ID. BD310374898

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-10	02-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-10	02-25-10	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	53,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0388

PEN)YLVANIA LIFE INSURANCE CO..PANY

P. O. Box 12355, Pensacola, FL 32591-2355

8050

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom
   Po Box 1997 Irmo SC 29063
   Dr. Suarez + Dr. Desmond Lexington Orthopedics
   146 N. Hospital Dr. Suite 148
   West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr Odom - 3-15-10
   Dr. Suarez - 2-25-10

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged:

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

MAIL CENTER
APR 12 2010
PENSACOLA

DATE: 4-5-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0391

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

8C9C

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENT

JUN 2 2 2010

PENSACO

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803 955 0329	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803 513 0575		Policy No: [redacted] 9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Elgin, SC 29063
   Dr. Sloree + Dr. Dedmond - Lexington Med. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   5-17-10

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing exercises, reading, etc.

DATE: 6-17-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3.R

PLIC 0392

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310385246	07/20/10	4210059426	$******7,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVEN THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210059426
CHECK DATE 07/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-20-10
CLAIM NO. 0809-00062 REF ID. BD310385246

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-10	05-25-10	3MO	2000M	6,000.00
	TOTAL DISABILITY	02-25-10	05-25-10	3MO	500M	1,500.00
					TOTAL THIS PAYMENT	7,500.00
					TOTAL PAID TO DATE	60,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0393

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310385246	07/20/10	4210059426	$******7,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVEN THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures. **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210059426
CHECK DATE 07/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-20-10
CLAIM NO. 0809-00062 REF ID. BD310385246

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-10	05-25-10	3MO	2000M	6,000.00
	TOTAL DISABILITY	02-25-10	05-25-10	3MO	500M	1,500.00
					TOTAL THIS PAYMENT	7,500.00
					TOTAL PAID TO DATE	60,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0389

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

AUG 23 2010

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Redmond - Lexington Orthopedics 1460 Hospital Dr. Ste 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
7-19-10

4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing exercises, reading, etc.

DATE: 8-19-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0394

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310387907	08/26/10	4210062075	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210062075
CHECK DATE 08/26/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 08-26-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310387907

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-10	07-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-10	07-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	65,625.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0395

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310387907	08/26/10	4210062075	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of: MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210062075
CHECK DATE 08/26/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 08-26-10
CLAIM NO. 0809-00062 REF ID. BD310387907

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-10	07-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-10	07-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	65,625.00

PARTIAL PAYMENT

ADJ. 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0390

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310390322	09/23/10	4210064481	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures. **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210064481
CHECK DATE 09/23/10

PENNSYLVANIA LIFE INS CO

INSURED: MIKE RUSSELL
DEPENDENT:

POLICY NO. [redacted]9360 DATE PAID 09-23-10
CLAIM NO. 0809-00062 REF ID. BD310390322

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-10	08-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-10	08-25-10	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	68,125.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0396

PENN. LVANIA LIFE INSURANCE CO ANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

SEP 28 2010

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number: Home 803-955-0339, Cell, ~~Work~~ 803-513-0525 Age: 38

Claim No: 02-001-001-080900062
Policy No: [redacted]9360

1. Describe the conditions causing your disability:	motorcycle accident - broken hip + leg
2. What is the name and address of all physicians currently treating you? Dr Odom PO Box 1997 Irmo, SC 29063	Dr Suarez + Dr Desmond - Lexington Orthopedics 146 N. Hospital Dr Suite 940 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	7-19-10
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 9-22-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0397

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310392593	10/18/10	4210066744	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210066744
CHECK DATE 10/18/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 10-18-10
CLAIM NO. 0809-00062 REF ID. BD310392593

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	08-25-10	10-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	08-25-10	10-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	73,125.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0398

PENN[illegible]LVANIA LIFE INSURANCE CO[illegible]ANY

P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	
Cell	Home	803-955-0339	38	Claim No: 02-001-001-080900062
~~Work~~		803-513-0575		Policy No: [redacted]9300

1. Describe the conditions causing your disability.
   motorcycle accident - broken hip + leg
2. What is the name and address of all physicians currently treating you? Dr Odom
   Po Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Desmond - Lexington Orthopedics
   146 N Hospital Dr. Suite 140
   West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   Dr Odom - 9/9/10 Dr Suarez 10-6-10
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   Unknown
8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing exercises, reading etc.

MAIL CENTER
NOV 08 2010
PENSACOLA

DATE: 11-2-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0399

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310395224	11/22/10	4210069375	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY: *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of: MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210069375
CHECK DATE 11/22/10

PENNSYLVANIA LIFE INS CO

INSURED MIKE RUSSELL — POLICY NO. [redacted]9360 — DATE PAID 11-22-10
DEPENDENT — CLAIM NO. 0809-00062 — REF ID. BD310395224

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-10	11-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-10	11-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		75,625.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0400

PENN 'LVANIA LIFE INSURANCE CO 'ANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 38	Claim No: 02-001-001-080900062
	Cell Work	803-513-0525		Policy No [redacted]9360

1. Describe the conditions causing your disability: motorcycle accident broken b.p+leg

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Ermo, SC 29063 — Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report? 11-17-10

4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.) — Hospital _____ Address _____ Admitted: _____ Discharged _____

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began. — Describe work or activities: _____ Date these duties first performed: _____

7. When do you expect to begin working at all of your duties? unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.) ☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME: resting, walking TV, completing exercises, reading, etc.

MAIL CENTER
DEC 13 2010
RECEIVED

DATE: 12-8-10 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R

Rev 4-97

PLIC 0401

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310397566	12/20/10	4210071712	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210071712
CHECK DATE 12/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 12-20-10
CLAIM NO. 0809-00062 REF ID. BD310397566

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-10	12-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	11-25-10	12-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		78,125.00

PARTIAL PAYMENT

ADJ 0077 STATE 38 S/C 0044413 M/C 091477

PLIC 0402

PENNSY ANIA LIFE INSURANCE COMP IY 17773

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIKE AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
JAN 18 2011
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 38	Claim No 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken hip + leg

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063
Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 1146 D Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
mid-December - go back 1-10-11

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 1-13-11 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0403

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

Forwarding Service Requested

3-DIGIT 290
8670 0 7130 AT 0 354
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
58

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 8670 1 OF 3 F

Check Enclosed: Yes
Check Date: 01/26/2011
Check #: 8810702344
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
12/25/10 - 01/24/11 – TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
12/25/10 - 01/24/11 – TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810702344
CHECK DATE: 01/26/2011

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0404

PENN 'LVANIA LIFE INSURANCE CO 'ANY

P. O. Box 12355, Pensacola, FL 32591-2355

807

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	~~Work~~ cell	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063	Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	1-19-11
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: _____ Address: _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: _____ Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting watching TV, completing exercises, reading, etc.

DATE: 2-17-11 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia SC 29172

C-3 R Rev. 4-97

PLIC 0405

PE25021002

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

[redacted]

Forwarding Service Requested

3-DIGIT 290

777 0.7130 AT 0.354

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2951

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 777 1 OF 3 F

Check Enclosed: Yes
Check Date: 03/02/2011
Check #: 8810713313
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
01/25/11 - 02/24/11 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
01/25/11 - 02/24/11 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810713313
CHECK DATE: 03/02/2011

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0406

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

Forwarding Service Requested

MIXED AADC 290
22770 0.7130 MB 0.379
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

428

ENV 22770 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 03/09/2011
Check #: 8810714771
Check Amount: 333.33

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
02/25/11 - 02/28/11 -- TOTAL DISABILITY BENEFITS	333.33	333.33	0.00	0.00	333.33	471
Claim Totals:	333.33	333.33	0.00	0.00	333.33	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810714771
CHECK DATE: 03/09/2011

AMOUNT
*****$333.33

Void if not Cashed Within 90 Days

PAY Three Hundred Thirty Three & 33/100 Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0408

PENN 'LVANIA LIFE INSURANCE CO 'ANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

17773

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number cell:	Home: 803-955-0329	Age: 38	Claim No: 02-001-001-08090006.2
	Work: 803-513-0515		Policy No [redacted]9360

1. Describe the conditions causing your disability.
   Motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? D. Odom PO Box 1997 Irmo SC 29063
   Dr. Suarez, Dr. Diamond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   1-19-11 - next 3-23-11
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, waiting TV, completing exercises, reading, etc.

MAIL CENTER
MAR 29 2011
PENSACOLA

DATE: 3-23-11 SIGNED: Mike Russell

ADDRESS: 146A Dogwood Rd West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0407

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

Forwarding Service Requested

3-DIGIT 290
1150 0.7130 AT 0.354
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 1150 1 OF 3 F

Check Enclosed: Yes
Check Date: 04/01/2011
Check #: 8810720061
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
03/01/11 - 03/31/11 --	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810720061
CHECK DATE: 04/01/2011

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0409

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

Forwarding Service Requested

3-DIGIT 290
3381 0.7130 AT 0.362
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

1 OF 3 F
ENV 3381

Check Enclosed: Yes
Check Date: 04/29/2011
Check #: 8810728796
Check Amount: 2,500.00
Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
04/01/11 - 04/30/11 = TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810728796
CHECK DATE: 04/29/2011

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0410

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

80%

17773

MAIL CENTER

MAY 02 2011

PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Elgin, SC 29045
Dr. Suarez + Dr. Desmond - Lexington 1146 N. Hospital Dr. Suite MD West Columbia, SC 29169 — Orthopedics

3. On what dates were you treated since completing your last report?
3-23-11

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital:
Address:
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, working to, completing exercises, reading, etc.

DATE: 4-28-11 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0429

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	See previous
2. Describe any other conditions contributing to present disability.	See previous
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report:
3a Next Appointment Date:	Patient discharged on: 3/23/11
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 4-26-11 SIGNED: Randall S. Mikulz, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste. 140
West Columbia, SC 29169
(803) [illegible]-7230 TELEPHONE

C-3 R Rev. 3-96

PLIC 0430

PR250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2227 0.7130 AT 0.362
MIKE RUSSELL 10
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

20110527013I

ENV 2227 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 05/27/2011
Check #: 8810736498
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	Patient Name: MIKE RUSSELL			Date of Birth: [redacted]		
Provider:	Patient Acct #:			Policy No: [redacted]9360		
05/01/11 - 05/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY.

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810736498
CHECK DATE: 05/27/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0481

P6250028007

20110527B131

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 2227

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

P8250028007

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2227 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20160329015

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

3 OF 3 F

ENV 2227

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

8076

ENV 3381 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 03-001-001-0809 00063
	Home	803 955 0309		
Cell	Work	803-513-0575	38	Policy No: [redacted] 9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohd 3 rides pain mgmt 109 Midlands Ct, West Columbia, SC 29169
Dr. Suarez + Dr. Desmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
4-21-11 ; 5-6-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital:
Address:
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching tv, completing exercises, reading, etc.

DATE: 5-20-11 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0431

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 3381 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	Same
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report: NA
3a. Next Appointment Date: NA	Patient discharged on: 3-23-11
4. Has the patient been confined to a hospital since completing your last report? NA (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address: Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	NA
6. When did or will your patient be able to resume full work?	NA
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

MAIL CENTER
JUN 02 2011
PENSACOLA

Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

DATE: 5-25-11 SIGNATURE: Randall S. Murray, MSW

ADDRESS: TELEPHONE:

C-3 R Rev 11/10

PLIC 0432

P8250078002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO.
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

20110727014G

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 39752 1 OF 3 F

MIXED AADC 290
39752 0.7130 MB 0.387
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
299

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 07/27/2011
Check #: 8810751432
Check Amount: 5,000.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted] **Provider:** **Patient Acct #:** **Policy No:** [redacted]9360						
06/01/11 - 06/30/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
07/01/11 - 07/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	5,000.00	5,000.00	0.00	0.00	5,000.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810751432
CHECK DATE: 07/27/2011

AMOUNT
*****$5,000.00

Void If not Cashed Within 90 Days

PAY Five Thousand Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0496

FR2500260007

20101072010496

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 39752

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home:		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

FR250028007

20110727046

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 39752 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address: _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20100720146

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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3 OF 3 F

ENV 39752

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-276-7366

8076

ENV 2227 2 OF 3 R

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-0809000062
	Cell / Work	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Motto - 3 Rivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169
Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
5-6-11, 7-1-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital: MAIN
Address:
Admitted: JUL 11 2011
Discharged: PENSACOLA

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching tv, completing exercises, reading, etc.

DATE: 7-1-11 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

Page 1 of 4

PAID 7/26/11 QC

PLIC 0433

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12365, Pensacola, FL 32591-2365 Toll Free 1-800-275-7368

ENV 2227 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care. patient remains under my care and is seen q 4-8 weeks	Dates of treatment since last report: 4/21/11, 5/6/11, 7/1/11
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Hospital: N/A Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? unknown	
6. When did or will your patient be able to resume full work? unknown	
7. As a result of this condition, was the patient confined to the house? NO If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/1/11 SIGNATURE

ADDRESS 169 A Medical Circle, W. Columbia, SC 29169 TELEPHONE 803-454-1641

C-3 R Rev 11/10

PLIC 0434

PLS5021007 JDE25903109

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 777 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	~~Work~~			
	Cell	803-513-0575	39	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mollo - Shivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169
Dr. Suarez & Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
7-1-11

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 8-3-11 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0435

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12365, Pensacola, FL 32591-2365 Toll Free 1-800-275-7366

8076

AUG 08 2011
MAIL CENTER
PENSACOLA

ENV777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt. is seen Q 4-8 weeks for the management of this pain medications	Dates of treatment since last report: 4/21, 5/6, 7/1
3a. Next Appointment Date: 8/26/11	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? no	Hospital: N/A
(If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Address: _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity? unknown	
6. When did or will your patient be able to resume full work? unknown	
7. As a result of this condition, was the patient confined to the house? N/A If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Questions of disability +/or fitness to work lie outside the scope of this practice and will not be addressed. If not already done, I would recommend that this patient be referred for a Functional Capacity Evaluation, followed by an Independent Medical Evaluation by a Rehabilitation Medicine Specialist, within whose expertise these questions more appropriately lie.

Ind. Practitioner's Soc. Sec. # [redacted]

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/11 SIGNATURE _____

ADDRESS 169 A Medical Circle TELEPHONE 803-454-1661
West Columbia, S.C. 29169

C-3 R Rev 11/10

Page 2 of 4

8/22

PAID

PLIC 0436

P8250025002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
12777 D.7130 AT D.362
MIKE RUSSELL 58
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

20110824014S

ENV 12777 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 08/24/2011
Check #: 8810758384
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted]						
Provider: Patient Acct #: Policy No: [redacted]9360						
08/01/11 - 08/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810758384
CHECK DATE: 08/24/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0501

PB250028007

20110824014S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 12777

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

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USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0502

F8250028007

20110826145

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 12777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: SIGNATURE

ADDRESS TELEPHONE

C-3 R Rev.11/10

PLIC 0503

20110324043

STATE REGULATORY FRAUD NOTICES

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ENV 12777 3 OF 3 F

STATE REGULATORY FRAUD NOTICES

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RM05477711

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12365, Pensacola, FL 32591-2365 Toll Free 1-800-275-7366

2 OF 3 F

ENV 39752

PAID 092811 JP

IMAGING

SEP 01 2011

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 02-001-001-080900062
Home	803-955-0329			
Work	803-513-0575	.39		Policy No: [redacted]3600

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip + pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohq - 3 Rivers Pain mgmt. 109 Midlands Ct West Columbia, SC 29169
Dr. Swartz + Dr. Redmond - Lexington Orthopedics 146 D. Hospital Dr. Suite 140 West Columbia SC 29169

3. On what dates were you treated since completing our last report?
7-1-11, 8-26-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, walking to, completing exercises, reading, etc.

DATE: 8-26-11 SIGNATURE [signature] Russell

ADDRESS: 114691 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

Page 1 of 4

PLIC 0437

RMO5477711

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 39752 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 Pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen q 4-8 weeks for the management of his medications	Dates of treatment since last report: 4/21, 5/16, 7/1, 8/26
3a. Next Appointment Date:	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Hospital: N/A Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? unknown	
6. When did or will your patient be able to resume full work? unknown	
7. As a result of this condition, was the patient confined to the house? NO If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Questions of disability +/or fitness to work lie outside the scope of this practice and will not be addressed. If not already done, I would recommend that this patient be referred for a Functional Capacity Evaluation, followed by an Independent Medical Evaluation by a Rehabilitation Medicine Specialist, within whose expertise these questions more appropriately lie.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 8/26/11 SIGNATURE

ADDRESS 169A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

Page 2 of 4

PLIC 0438

ROA 891

RMO8525300

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 12777 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name:

IMAGING
OCT 11 2011

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age:	39
	~~Work~~ Cell	803-513-0575		

Claim No: 02-001-001-0809000 02
Policy No: [redacted]3360

1. Describe the conditions causing your disability. motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. mono - 3 rivers Pain mgmt 109 midlands Ct. West Columbia, SC 29169
Dr. Suarez + Dr. Dadmon - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
8-26-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 10/4/11 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C3 R Rev 11/10

PLIC 0439

RMO6525300

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12365, Pensacola, FL 32591-2365 Toll Free 1-800-275-7366

ENV 12777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: Pain in limb - 729.5	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8 weeks for the mgmt. of his chronic medications.	Dates of treatment since last report: 4/21, 5/6, 7/1, 8/26, 9/9, 11/3
3a. Next Appointment Date: 11/3/11	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? NO If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 10/4/11 SIGNATURE

ADDRESS 1169A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

Page 2 of 4

PLIC 0440

PB250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

201110260135

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

[redacted]

ENV 12423 1 OF 3 F

3-DIGIT 290
12423 0.7130 AT 0.362

MIKE RUSSELL 53
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 10/26/2011
Check #: 8810773923
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
10/01/11 - 10/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810773923
CHECK DATE: 10/26/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0516

P#250028007

20111020155

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 12423

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home Work		Age:	Claim No: Policy No:

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev.11/10

PLIC 0517

PR250028007

20111026035

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 12423 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

C-3 R Rev 11/10

PLIC 0518

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

3 OF 3 F

ENV 12423

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2376 0.7130 AT 0.362
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

9

20111230140

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 2376 1 OF 3 F

Check Enclosed: Yes
Check Date: 11/23/2011
Check #: 8810780557
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062	Patient Name: MIKE RUSSELL			Date of Birth: [redacted]		
Provider:	Patient Acct #:			Policy No: [redacted]9360		
11/01/11 - 11/30/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy, provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810780557
CHECK DATE: 11/23/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0526

F8250028007

20111232140

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 2376

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PB25002E007

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: SIGNATURE

ADDRESS TELEPHONE

C-3 R Rev 11/10

PLIC 0528

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name:

IMAGING
DEC 27 2011

CLAIMANT'S REPORT

Telephone Number: Home ~~Work~~ Cell		Age:	Claim No: 02-001-001-08090006a
Home: 803-955-0329	Cell: 803-513-0575	39	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mollo-3 rivers Pain mgmt 109 Midlands Ct. West Columbia, SC 29169
Dr. Suarez + Dr. Redmond - Lexington orthopedics 146 N. Hospital Dr. Suite 110 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
12-2-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: 12-21-11 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd West Columbia SC 29172

C3 R Rev 11/10

PLIC 0441

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: Pain in limb - 729.5	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt. is seen Q4-8 weeks for the mgmt. of his medications	Dates of treatment since last report: 4/1, 5/6, 7/1, 8/26, 9/9, 11/13,
3a. Next Appointment Date:	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? no If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 12/21/11 SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1616

C-3 R Rev 11/10 Page 2 of 4

PLIC 0442

P#250025062

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
959 0.7130 AT 0.362
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 959 1 OF 3 F

Check Enclosed: Yes
Check Date: 12/28/2011
Check #: 8810788164
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted] Provider: Patient Acct #: Policy No: [redacted]9360						
12/01/11 - 12/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810788164
CHECK DATE: 12/28/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0536

PB250026007

20111220125

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 959

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: SIGNATURE

ADDRESS TELEPHONE

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-276-7366

ENV 959 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name:

MAIL CENTER
JAN 30 2012
PENSACOLA

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 39	Claim No: 03-001-001-030900062
Cell	~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability: motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohd - 3 Rivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169 — Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report? 12-2-11

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties? Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Reading, watching TV, Completing exercises, etc.

DATE: 1-25-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10 Page 1 of 4

PLIC 0443

ROA 911

RMO5573693

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7388

ENV 959 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 Pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. patient seen Q4-8 weeks for the mgmt of his medications	Dates of treatment since last report: 4/1, 5/6, 7/1, 8/26, 9/9, 11/3, 12/2
3a. Next Appointment Date: 1/27/12	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other Employer I.D. #

Must be furnished under authority of the law

DATE: 1/24/12 SIGNATURE

ADDRESS 1169 A Medical Circle W. Columbia S.C. 29169 TELEPHONE 803-454-1616

C-3 R Rev 11/10

Page 2 of 4

PLIC 0444

P8250018003

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
6053 0.7130 AT 0.371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
42

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201203010133

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 6053 1 OF 3 F

Check Enclosed: Yes
Check Date: 03/01/2012
Check #: 8810801176
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted] Provider: Patient Acct #: Policy No: [redacted]9360						
02/01/12 - 02/29/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
02/01/12 - 02/29/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1270/611

CHECK NO: 8810801176
CHECK DATE: 03/01/2012

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0461

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law.

DATE: SIGNATURE

ADDRESS TELEPHONE

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DCL6719130

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2018
PENSACOLA

MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172
29172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 02-001-001-080900062
	Home	803-965-0329	39	Policy No: [redacted]9380
	Cell			
	~~Work~~	803-513-0675		

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you? Dr. Moho-Jinwoos pain mgmt 109 Midlands Ct. West Columbia, SC 29169
   Dr. Suarez + Dr. Dodmond- Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   1-27-18
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Reading, Watching TV, Completing exercises etc.

DATE: 2-28-18 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0445

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition.
ICD Code: 729.5-pain in limb

2. Describe any other conditions contributing to present disability. N/A

3. Describe dates of treatment since last report and indicate if patient is still under your care
Yes- medication mgmt

3a. Next Appointment Date:
3/14/12

Dates of treatment since last report: 4/1/11, 5/6/11, 7/1/11, 8/26/11, 9/9/11, 11/5/11, 12/2/11,
Patient discharged on: N/A 1/27/12

4. Has the patient been confined to a hospital since completing your last report?
NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)

Hospital
Address
Admitted: Discharged

5. When did or will your patient be able to resume some work or activity? N/A

6. When did or will your patient be able to resume full work? N/A

7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined.
(See definition of CONFINEMENT below.) N/A

☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2/22/12 SIGNED:

ADDRESS: 169A Medical Circle
West Columbia, S.C. 29169

TELEPHONE (803) 454-1161

C-3 R

Rev. 3-96

DOL67/9130

PLIC 0446

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
845 0.7130 AT 0.371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172-2451

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 845 1 OF 3 F

Check Enclosed: Yes
Check Date: 03/28/2012
Check #: 8810806996
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 00809000062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
03/01/12 - 03/31/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
61-1278/611

CHECK NO: 8810806996
CHECK DATE: 03/28/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0466

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PLIC 0467

ROA 921

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address_____ Admitted:_____ Discharged:_____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE_____

ADDRESS_____ TELEPHONE_____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

3 OF 3 F

ENV 845

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

BKE5759192

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 6055 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name:

MAIL CENTER
APR 03 2012
PENSACOLA

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age:	Claim No: 03-001-001-080900062
	Cell	~~Work~~ 803-513-0575	39	Policy No: [redacted] 93.60

1. Describe the conditions causing your disability: motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mono - Shivers Pain Mgmt 109 Midlands Ct. West Columbia, SC 29169 — Dr. Suarez & Dr. Redmond - Lexington Orthopedics 140 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report? 3-14-12

4. Have you been confined to a hospital since completing your last report? NO

(If "YES", give date of confinement and attach a copy of your hospital bill).

Hospital _____

Address _____

Admitted: _____

Discharged: _____

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.

Describe work or activities: _____

Date these duties first performed: _____

7. When do you expect to begin working at all of your duties? Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)

☐ YES, I have been confined to the house since completing my last report.

☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Reading, watching TV, completing exercises, etc.

DATE: 3-29-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10 Page 1 of 4

PLIC 0447

BKE6759192

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 6053 2OF3B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. n/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8wk for med. mgmt.	Dates of treatment since last report: 3/14/12
3a. Next Appointment Date: 5/7/12	Patient discharged on: n/A
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? n/A	
6. When did or will your patient be able to resume full work? n/A	
7. As a result of this condition, was the patient confined to the house? NO If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 3/29/12 SIGNATURE

ADDRESS 169 A Medical Circle TELEPHONE 803-454-1161

West Columbia, S.C. 29169

C-3 R Rev 11/10

PLIC 0448

P1250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

20120425011?

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 17395 1 OF 3 F

ALL FOR AADC 290
17395 0-7130 AB 0-371
MIKE RUSSELL 161
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 04/25/2012
Check #: 8810813434
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 Provider:		Patient Name: MIKE RUSSELL Patient Acct #:		Date of Birth: [redacted] Policy No: [redacted]9360		
04/01/12 - 04/30/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810813434
CHECK DATE: 04/25/2012

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0471

PR25002E00C

20120425D117

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 17395

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No:
	Work			Policy No: [redacted]9360

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0472

PE250028000

20120450117

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 17395 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

C-3 R Rev 11/10

PLIC 0473

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 845 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 39	Claim No: 03-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted] 93600

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohd - Shivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169
   Dr. Soorez - Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 148 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
   3-14-12

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill).
   Hospital
   Address
   Admitted:
   Discharged:

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Reading, watching TV, Completing exercises, etc.

MAIL SECTION
MAY 15 2012
PENSACOLA

DATE: 5-8-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10 Page 1 of 4

PLIC 0449

ROA 932

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8 weeks for med. mngmt	Dates of treatment since last report: 5/7/12
3a. Next Appointment Date:	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address: Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? no If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 5/7/12 SIGNATURE

ADDRESS 169 A Medical Circle West Columbia, SC 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0450

P8250028001

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
1248 0.7130 AT 0.371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
12

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV1248 1 OF 3 F

Check Enclosed: Yes
Check Date: 05/23/2012
Check #: 8810819713
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062	Patient Name: MIKE RUSSELL			Date of Birth: [redacted]		
Provider:	Patient Acct #:			Policy No: [redacted]360		
05/01/12 - 05/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
05/01/12 - 05/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810819713
CHECK DATE: 05/23/2012

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0476

P8350028000

20120523011G

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 1248

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PR2500/R00C

20120523011G

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 1248 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address_____ Admitted:_____ Discharged:_____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE:_____ SIGNATURE_____

ADDRESS_____ TELEPHONE_____

C-3 R Rev 11/10

PLIC 0478

STATE REGULATORY FRAUD NOTICES

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NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

BKE5868654

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 1248

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-0809000062
	~~Work~~ Cell	803-513-0575	39	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mollo - 3 Rivers Pain Mgmt, 109 Midwoods Ct. West Columbia, SC 29169
Dr. Suarez + Dr. Olsmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140, West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
6-7-12

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital:
Address:
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

MAIL CENTER
JUN 18 2012
PENSACOLA

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Reading, watching TV, completing exercises, etc.

DATE: 6-12-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0451

PR13031800C

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 1248 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5- pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8w for med. mgmt.	Dates of treatment since last report: 5/7/12.
3a. Next Appointment Date: 6/22/12	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. no (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 6/12/12 SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, SC. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0452

PH250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
13704 0.7130 MB 0.401
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
327

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201207110120

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 13704 1 OF 3 F

Check Enclosed: Yes
Check Date: 06/29/2012
Check #: 8810828330
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Provider:**	**Patient Name:** MIKE RUSSELL **Patient Acct #:**			**Date of Birth:** [redacted] **Policy No:** [redacted]9360		
06/01/12 - 06/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
06/01/12 - 06/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810828330
CHECK DATE: 06/29/2012

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0486

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices:: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home:		Age:	Claim No: Policy No: [redacted]9360
	Work:			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

20120711012D

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 13704

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 17395

mike russell
1469 Dogwood Rd.
West Columbia, SC 29172
Dependent Name: MIKE RUSSELL

RECEIVED
JUL 20
By

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-0809000062
	Cell ~~Work~~	803-513-0575	40	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohd - 3 Rivers Pain Mgmt - 109 Midlands Ct. West Columbia, SC 29169
Dr. Redmond + Dr. Suarez - Lexington Ortho pedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
6-22-12

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Reading, watching TV, completing exercises, etc.

DATE: 7-16-12 SIGNATURE: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0453

PRU500/2800C

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV:17395 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8 weeks for med mngmt	Dates of treatment since last report: 6/22/12
3a. Next Appointment Date: 8/14/12	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? no If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/16/12 SIGNATURE

ADDRESS 169A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev.11/10

PLIC 0454

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
863 0.7130 AT 0.371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

201207250121

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 863 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 07/25/2012
Check #: 8810833168
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
07/01/12 - 07/31/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810833168
CHECK DATE: 07/25/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF **MIKE RUSSELL**

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0491

P8250028000C

20120729121

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 863

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

20120725012

STATE REGULATORY FRAUD NOTICES

ENV 863 3 OF 3 B

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

BKE5940737

UNION BANKERS INSURANCE COMPANY

On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 863 2 OF 3 F

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name: MIKE RUSSELL

RECEIVED
AUG 27 2012
By

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 02-001-001-0809000068
Home	803-955-0329			
Cell	~~Work~~ 803-513-0575	40		Policy No: [redacted]9360

1. Describe the conditions causing your disability: Motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohr 3 Rivers Pain Mgmt. 109 Midlands Ct. West Columbia SC 29169 — Dr. Redmond + Dr. Suarez - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report? 6-22-12, 8-14-12

4. Have you been confined to a hospital since completing your last report? no

(If "YES", give date of confinement and attach a copy of your hospital bill).

Hospital _____

Address _____

Admitted: _____

Discharged: _____

5. Have you performed any work or activities since completing your last report? ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.

Describe work or activities: _____

Date these duties first performed: _____

7. When do you expect to begin working at all of your duties? unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)

☐ YES, I have been confined to the house since completing my last report.

☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Reading, watching tv, completing exercises, etc.

DATE: 8-21-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0455

P025002B00C

BKE5940737

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV.863 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition: ICD CODE: 729.5 pain in limb	
2. Describe any other conditions contributing to present disability. n/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt. is seen Q4-8 weeks for med mgmt	Dates of treatment since last report: 8/14/12
3a. Next Appointment Date: 10/9/12	Patient discharged on: n/A
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? n/A	
6. When did or will your patient be able to resume full work? n/A	
7. As a result of this condition, was the patient confined to the house? no If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 8/20/12 SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, S.C. 29123 TELEPHONE: 803-454-1661

C-3 R Rev 11/10.

PLIC 0456

P8256028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
19181 D-7130 MB 0.401
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
437

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

2012082900118

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV:19181 1 OF 3 F

Check Enclosed: Yes
Check Date: 08/29/2012
Check #: 8810840118
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Provider:**		**Patient Name:** MIKE RUSSELL **Patient Acct #:**		**Date of Birth:** [redacted] **Policy No:** [redacted]9360		
08/01/12 - 08/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
08/01/12 - 08/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810840118
CHECK DATE: 08/29/2012

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0506

PR250028000

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 19181 2 OF 3 F

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev.11/10

PLIC 0507

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below:)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20150829011B

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name: MIKE RUSSELL

RECEIVED
OCT 01 2012
By

ENV 19181 2 OF 3 F

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 40	Claim No: 08-001-001-0809000628
Cell	~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip + pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mollo - 3 Rivers Pain Management
109 Midlands Ct. West Columbia, SC 29169
Dr. Desmond + Stores - Lexington Orthopaedics
146 D. Hospital Dr. Suite 140
West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
8-14-12

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: 9-25-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0457

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 1918J 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 Pain in limb 784.0 - Cephalgia	
2. Describe any other conditions contributing to present disability: N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8 weeks for med. mgmt	Dates of treatment since last report: 8/14/12
3a. Next Appointment Date: 10/9/12	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address: Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? NO If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/25/12 SIGNATURE: [signature]

ADDRESS 169 A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

CJR Rev 11/10

PLIC 0458

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
917 0:7130 AT 0:371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451
13

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201210240116

ENV 917 1 OF 3 F

Call 888-802-9497 to speak with us.

Check Enclosed: Yes
Check Date: 10/17/2012
Check #: 8810850706
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
09/01/12 - 09/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
09/01/12 - 09/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810850706
CHECK DATE: 10/17/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0511

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20121024016

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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STATE REGULATORY FRAUD NOTICES

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NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 13704

Mike Russell
1469 Dogwood Rd.
West Columbia, SC 29172

Dependent Name: MIKE RUSSELL

NOV 05 2012

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 03-001-001-080900067
	Cell / ~~Work~~	803-513-0575	40	Policy No: [redacted]79360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohio-3 Rivers Pain Management 109 Midland Ct. West Columbia, SC 29169
Dr. Desmond + Dr. Suarez — Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
10-9-12

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill).
Hospital
Address
Admitted:
Discharged:

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
reading, watching TV, completing exercises, etc.

DATE: 10-31-12 SIGNATURE Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev 11/10

PLIC 0459

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7368

FNV 11/04 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8 weeks for med mgmt	Dates of treatment since last report: 10/9/12
3a. Next Appointment Date: 12/11/12	Patient discharged on: N/A
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address: Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? UNK If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 10/30/12 SIGNATURE

ADDRESS 169 A Medical Circle West Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0460

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

201211140114

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

1 OF 3 F

ENV 13730

MIXED AADC 290
13730 0.7130 MB 0.401

MIKE RUSSELL 358
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

Call 888-802-9497 to speak with us.

Check Enclosed: Yes
Check Date: 11/14/2012
Check #: 8810855783
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
10/01/12 - 10/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
10/01/12 - 10/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810855783
CHECK DATE: 11/14/2012

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0521

P825002800C

20121114014

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 13730

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No:
	Work			Policy No: [redacted]9360

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☒ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0522

P625002800C

20121140114

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 B

ENV 13730

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2865 0-7130 AT 0-371
MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

201211300116

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us.

ENV 2865 1 OF 3 F

Check Enclosed: Yes
Check Date: 11/30/2012
Check #: 8810859249
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062	**Patient Name:** MIKE RUSSELL			**Date of Birth:** [redacted]		
Provider:	**Patient Acct #:**			**Policy No:** [redacted]9360		
11/01/12 - 11/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
11/01/12 - 11/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810859249
CHECK DATE: 11/30/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0531

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability:	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital _____ Address _____ Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☐ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities, which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

P825002S00C

20121130116

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 B

ENV 2865

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care.	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill).	Hospital: Address _____ Admitted: _____ Discharged: _____
5. When did or will your patient be able to resume some work or activity?	
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☐ NO

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THIS SPACE IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

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NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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STATE REGULATORY FRAUD NOTICES

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NOTICE IN ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.