

SERFF Tracking Number: LWEL-126388249 State: Arkansas
 Filing Company: AmFirst Insurance Company State Tracking Number: 44200
 Company Tracking Number: AF-GTLP (11/09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life Insurance Plan
 Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Filing at a Glance

Company: AmFirst Insurance Company

Product Name: Group Term Life Insurance Plan SERFF Tr Num: LWEL-126388249 State: Arkansas

TOI: L04G Group Life - Term SERFF Status: Closed-Approved- State Tr Num: 44200
 Closed

Sub-TOI: L04G.500 Other Co Tr Num: AF-GTLP (11/09) State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Author: Rebecca Ewing Disposition Date: 12/03/2009

Date Submitted: 11/30/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Term Life Insurance Plan

Status of Filing in Domicile: Pending

Project Number: AF-GTLP (11/09)

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 12/03/2009

Explanation for Other Group Market Type:

State Status Changed: 12/03/2009

Deemer Date:

Created By: Rebecca Ewing

Submitted By: Rebecca Ewing

Corresponding Filing Tracking Number:

Filing Description:

This is a group term life plan. These forms are new and do not replace any forms previously filed and approved by your Department. The following forms are being submitted for your review and approval:

Form Description

AF-GTLP (11/09) Group Term Life Insurance Policy

AF-GTLC (11/09) Group Term Life Certificate of Coverage

AF-Large Group Life App (11/09) Employer Application for Group Term Life Insurance

AF-LIFELG-EnrForm (11/09) Life Enrollment/Change Form – Large Group

AF-Small Group Life App (11/09) Employer Application for Group Term Life

SERFF Tracking Number: LWEL-126388249 State: Arkansas
Filing Company: AmFirst Insurance Company State Tracking Number: 44200
Company Tracking Number: AF-GTLP (11/09)
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Term Life Insurance Plan
Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)
AF-LIFESG-EnrForm (11/09) Life Enrollment/Change Form (Small Group)

The policy is designed to provide employer group term life and related benefits to eligible employees. Benefits will include a Basic Life Benefit (\$10,000 to \$400,000 for the insured) and an Accelerated Death Benefit (not to exceed from 25% to 75% of the Basic Life Benefit). Telephonic Grief Counseling and Support will also be made available.

Optional benefits (at the election of the policyholder/employer) will include a Supplemental Life Benefit, an Accidental Death & Dismemberment Benefit, an Education Benefit for Qualified Children and a Repatriation Benefit.

Dependent coverage may also be made available.

The policyholder will use the appropriate group application when applying for coverage under this plan. Individual employees will use the appropriate enrollment form.

Domestic partner may be added to the number of eligible dependents at the election of the policyholder.

Please note that certain areas of text in these forms are bracketed to indicate that they are variable. Variability, as indicated by the use of "[]" brackets is being requested for content where required language may change subject to underwriting modification or negotiations with the policyholder. Where there is variability, we have given the range of variability in context. Variability is being requested to allow for the inclusion or exclusion of the bracketed material in its entirety. This latter request is needed so that we can delete text that is not applicable to the case-specific plan details (e.g. should a plan not require employee contribution, all references to such contribution would be deleted). A separate Statement of Variability is enclosed with this filing.

Thank you for your review of this filing. Please feel free to contact me if you have any questions or comments.

Sincerely,
Rebecca Ewing, FLMI, HIA, ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc.

Company and Contact

Filing Contact Information

Rebecca Ewing, Compliance Consultant rewing@lewisellis.com
P. O. Box 851857 972-850-3272 [Phone]
2929 N. Central Expy., Ste. 200 972-850-3273 [FAX]

SERFF Tracking Number: LWEL-126388249 State: Arkansas
 Filing Company: AmFirst Insurance Company State Tracking Number: 44200
 Company Tracking Number: AF-GTLP (11/09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life Insurance Plan
 Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Dallas, TX 75085-1857

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated)

AmFirst Insurance Company	CoCode: 60250	State of Domicile: Oklahoma
407 Briarwood Drive, Suite 201	Group Code: -99	Company Type:
Jackson, MS 39206	Group Name:	State ID Number:
(601) 956-2028 ext. [Phone]	FEIN Number: 640902785	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AmFirst Insurance Company	\$50.00	11/30/2009	32344818

SERFF Tracking Number: LWEL-126388249 State: Arkansas
Filing Company: AmFirst Insurance Company State Tracking Number: 44200
Company Tracking Number: AF-GTLP (11/09)
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Term Life Insurance Plan
Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/03/2009	12/03/2009

SERFF Tracking Number: *LWEL-126388249* *State:* *Arkansas*
Filing Company: *AmFirst Insurance Company* *State Tracking Number:* *44200*
Company Tracking Number: *AF-GTLP (11/09)*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.500 Other*
Product Name: *Group Term Life Insurance Plan*
Project Name/Number: *Group Term Life Insurance Plan/AF-GTLP (11/09)*

Disposition

Disposition Date: 12/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LWEL-126388249 State: Arkansas
 Filing Company: AmFirst Insurance Company State Tracking Number: 44200
 Company Tracking Number: AF-GTLP (11/09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life Insurance Plan
 Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Third Party Authorization Letter		Yes
Form	Group Term Life Insurance Policy		Yes
Form	Group Term Life Certificate of Coverage		Yes
Form	Employer Application for Group Term Life Insurance		Yes
Form	Life Enrollment/Change Form – Large Group		Yes
Form	Employer Application for Group Term Life		Yes
Form	Life Enrollment/Change Form (Small Group)		Yes

SERFF Tracking Number: LWEL-126388249 State: Arkansas
 Filing Company: AmFirst Insurance Company State Tracking Number: 44200
 Company Tracking Number: AF-GTLP (11/09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life Insurance Plan
 Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Form Schedule

Lead Form Number: AF-GTLP (11/09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AF-GTLP (11/09)	Policy/Cont	Group Term Life ract/Fratern Insurance Policy al Certificate	Initial		51.200	AmFirstGroup LifePolicy form.pdf
	AF-GTLC (11/09)	Certificate	Group Term Life Certificate of Coverage	Initial			AmFirst Group Certificate Form.pdf
	AF-Large Group Life App (11/09)	Application/ Employer Enrollment Form	Application for Group Term Life Insurance	Initial			AmFirst Group Employer 50+ application.pdf
	AF-LIFELG-EnrForm (11/09)	Application/ Life Enrollment Form	Enrollment/Change Form – Large Group	Initial			AmFirst GroupLife Enrollment Large.pdf
	AF-Small Group Life App (11/09)	Application/ Employer Enrollment Form	Application for Group Term Life	Initial			AmFirst Group Employer _2-50_ application.pdf
	AF-LIFESG-EnrForm (11/09)	Application/ Life Enrollment Form	Enrollment/Change Form (Small Group)	Initial			AmFirstGroup Life Enrollment Small.pdf

AmFirst Insurance Company

(Hereinafter called the Company, We, Our or Us)

Administrative Office:

5722 I-55 North Frontage Rd., Jackson, Mississippi 39211

Telephone 601-956-2028

(Herein called the Company)

For Inquiries, Information or Complaints, Please Call (800) 800-1397

GROUP TERM LIFE INSURANCE POLICY

POLICY AGREEMENT BY AND BETWEEN POLICYHOLDER AND AMFIRST INSURANCE COMPANY)

Policyholder: [_____]

Policy Number: [_____]

Policy Effective Date: [_____]

Premium Due Date: The Policy Effective Date and the first day of each month thereafter.

AmFirst Insurance Company (“the Company”) agrees to provide, for eligible persons becoming insured under the Policy, the benefits according to the terms, provisions and limitations of it. **The Policy is not to be construed to provide benefits required by Workers’ Compensation Laws.**

The Policy is issued in consideration of the Policyholder’s application, a copy of which is attached. The Policy becomes effective at 12:01 A.M. Eastern Standard Time on the Policy Effective Date shown above. The Policy will continue in force by the payment of premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Policyholder and the Company. If the Policyholder has any questions or problems with the Policy, the Company will be ready to help the Policyholder. The Policyholder may call upon his agent or the Company at [insert contact information for the Company] for assistance at any time.

IN WITNESS WHEREOF, the Parties hereto have executed the Policy to be effective as of the Policy Effective Date.

[INSERT GROUP NAME]

By: _____
Name

AMFIRST INSURANCE COMPANY

Title: _____

Date: _____

David White, President

POLICY GENERAL PROVISIONS

A. Certificates: The Company [will furnish to the Policyholder a Certificate of Coverage (“Certificate”) for delivery][will deliver a Certificate of Coverage (“Certificate”)] to each Covered Person (as such term is defined in the Certificate). The Certificate will describe the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

B. Conformity with State or Federal Statutes: If any provision of the Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of such law.

C. Entire Contract: The provisions of the Certificate, each employee enrollment form, and all amendments and/or riders attached thereto or endorse thereon on or after the Certificate Effective Date are incorporated into and made part of the Policy. The Policy, including the policy application, the Certificate, and any endorsements, riders, amendments or other attachments to the Policy, policy application or Certificate constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by the Company’s executive officer and unless such approval be endorsed hereon. Neither the Policyholder nor its agent has authority to change the Policy or to waive any of its provisions.

All statements made by the Policyholder and by the Covered Person under the Policy are representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy, unless:

1. It is contained in a written statement signed by the Covered Person; and
2. A copy of the statement is furnished to the Company by the Covered Person or his beneficiary.

Only the Company may change the Policy or extend the time for payment of any premium due under it. No change will be valid unless made in writing and signed by the Company. Any change so made will be binding on all persons referred to in the Policy. No agent has the authority to change the Policy or waive any of its provisions. For purposes of the Policy, the Policyholder acts on its own behalf and as the Covered Person’s agent. The Policyholder is not an agent of the Company.

D. Nonparticipation: The Policyholder will not be entitled to share in the Company’s surplus earnings.

E. Payment of Premiums: No insurance provided under the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying the premium amounts as set forth on Exhibit A attached hereto as they become due for the full period that the Policy is in effect. Premiums are payable on or before their due dates at [insert the Company’s payment address].

F. Grace Period: A grace period of 31 days from the premium due date will be allowed for the payment of each premium after the first premium payment. During this

grace period, the insurance will remain in effect. Payment of a premium for a period before it is due will not guarantee that the insurance will not be terminated pursuant to Section K below. [The Company will waive the Policyholder's premium payment on a monthly basis, beginning the first day of the month after the month a Covered Person becomes Totally Disabled (as such term is defined in the Certificate of Coverage) with respect to such Covered Person only. The Company will refund any premium paid under the Policy after that day. The Company will not refund premiums for any period more than {1-3 months} before the date proof of the Covered Person's Total Disability is furnished.]

G. Premium Rate Change: The Company has the right to change premium rates as of any premium due date but not more than once in any 6-month period; provided, however, that the Company may change premium rates at any time for reasons that affect the insured risk, including but not limited to the following:

1. a change in benefits;
2. the addition or deletion of a division, subsidiary, or affiliated company;
3. a change in the number of insured by [5 - 20%] or more;
4. the enactment of a new law or a change in any existing law that applies to the Policy.

Premium adjustments, refunds or charges will be made for only the current Policy year (except in the case of fraud). The Company will notify the Policyholder in writing at least 60 days prior to the change in rates; provided, however, that a change may take effect on an earlier date if both the Policyholder and the Company agree to it.

H. Termination of the Policy by Policyholder: The Policy may be terminated by the Policyholder. The Policyholder must notify its employees/participants in writing of such termination [10-90] days prior to the date of termination. Such written notice shall include a description of each employee's/participant's respective rights upon termination of coverage [, including the right to convert coverage upon termination]. The Company must be given [30-90] days prior written notice of termination and such notice must state the effective date of termination.

I. Termination of the Policy by the Company: The Policy may be terminated or modified by the Company if any of the following occurs:

- a. The Policyholder does not provide the Company with the information it needs to administer the Policy;
- b. The Policyholder fails to perform any of its obligations that relate to the Policy;
- c. [The number of Covered Persons under the Policy decreases to less than 2;]
- d. [The number of Eligible Employees (as such term is defined in the Certificate) increases or decreases by {5 - 20%};]
- e. The Policyholder fails to pay its premium within the grace period; [or]
- f. The Policyholder makes a material misrepresentation to the Company or its agents to obtain and/or maintain the Policy; [or]

- g. [If the Policyholder contributes partially towards the cost of insurance and less than 75% of all of the Policyholder's Eligible Employees are participating under the Policy;] [or]
- h. [If the Policyholder contributes in whole towards the cost of insurance and less than 100% of all of the Policyholder's Eligible Employees are participating under the Policy.]

If the Company exercises its right to terminate the Policy, it will: (a) provide 31 days advanced written notice of termination to the Policyholder; and (b) promptly return any unearned premium paid or the Policyholder will promptly pay any earned premium that has not been paid. Any earned or unearned premium will be determined on a pro rata basis.

J. Claim Determinations; ERISA Claim Fiduciary: For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Company is a claims fiduciary with complete authority to review all denied claims for benefits under the Policy. In exercising such fiduciary responsibility, the Company shall have discretionary authority to determine whether and to what extent Eligible Employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under the Policy or any other document incorporated herein. The Company shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. The Company has the right to adopt reasonable policies, procedures, rules, and interpretations of the Policy to promote orderly and efficient administration. Determinations made by the Company pursuant to this reservation of discretion do not prohibit or prevent any Covered Person from seeking judicial review in federal court of the Company's determinations after such Covered Person has exhausted the appeal procedures set forth in the Policy. This reservation of discretion only establishes the scope of review that a federal court will apply when such person seeks judicial review of the Company's determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions of the Policy's benefits. The federal court will determine the level of discretion that it will accord the Company's determinations. The Policyholder shall be responsible for making reports and disclosures required by ERISA. This includes the creation, the distribution, and the final content of (i) summary plan descriptions; (ii) summary of material modifications; and (iii) summary annual reports.

K. Fraud: The Company will use all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Policyholder knowingly, and with intent to injure, defrauds or deceives the Company, or files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of claims submitted under the Policy, and are subject to prosecution and punishment to the full extent permitted under state and/or federal law. The Company will pursue all appropriate legal remedies in the event of insurance fraud.

L. Incontestability: The Company may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. The Company may use a statement made by the Policyholder relating to its insurability to contest the validity of insurance under the Policy provided such statement is in writing and made not more than two years after the Policy Effective Date. This provision does not affect the Company's right to contest claims made for accidental death or accidental dismemberment benefits.

M. Information and Records to be Furnished: Upon request by the Company and within a reasonable time thereafter, the Policyholder shall furnish any information or records that have a bearing on insurance or that are required to administer the Policy, including, but not limited, information and records required by the Company to compute premiums and maintain necessary administrative records.

N. Clerical Error by Policyholder: Clerical error by the Policyholder will not: (a) affect the amount of insurance which would otherwise be in effect; (b) continue insurance which otherwise would be terminated; or (c) result in the payment of benefits not otherwise payable. Once an error is discovered, an equitable adjustment in the premium amount under the Policy will be made. Such adjustment will be made in the Company's sole discretion. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 3-month period preceding the date on which the Company receives proof that such an adjustment should be made. The Company may inspect any of the Policyholder's records relating to the Policy.

O. Misstatement of Age: If there is a misstatement of age with respect to a Covered Person [or a Dependent], an equitable adjustment in the premium amount under the Policy may be made to reflect such Covered Person's [or such Dependent's] correct age. Such adjustment will be made in the Company's sole discretion.

P. Effective Date of a Change in Benefits: Any modification to the Policy, including but not limited to a change in benefits or coverage, shall be effective as of the date of such modification.

Q. Amendment: Except as otherwise provided herein, the Policy may only be amended upon the written agreement of both parties; provided however, that the Company may unilaterally amend the Policy, including Exhibit A attached hereto, at any time by providing the Policyholder with thirty (30) days prior written notice thereof.

EXHIBIT A

PREMIUM AMOUNT AND PAYMENT SCHEDULE

[INSERT GROUP'S PREMIUM AMOUNT AND PAYMENT SCHEDULE]

AmFirst Insurance Company

**Administrative Office:
5722 I-55 North, Frontage Road
Jackson, Mississippi 39211
Telephone 601-956-2028**

(Herein called the Company)

For Inquiries, Information or Complaints, Please Call (800) 800-1397

GROUP TERM LIFE CERTIFICATE OF COVERAGE ("CERTIFICATE")

Policyholder: [_____]

Policy Effective Date: [_____]

Policy Number: [_____]

Covered Person: [_____]

Certificate Number: [_____]

Certificate Effective Date: [_____]

AmFirst Insurance Company ("the Company") issues the Certificate to the Covered Person as evidence of insurance under the Policy issued to the Policyholder by the Company. The Certificate describes the benefits and other important provisions of the Policy.

The Policy and Certificate may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in the Certificate insure the Covered Person, and, if applicable, any Dependents eligible for insurance. The Certificate becomes effective at 12:01 A.M. Eastern Standard Time on the Certificate Effective Date shown above.

Read the Certificate Carefully

The Certificate is a legal contract between the Covered Person and the Company. If the Covered Person has any questions or problems with the Certificate, the Company will be ready to help the Covered Person. The Covered Person may contact the Company at [insert number] for assistance at any time.

If the Covered Person has questions or needs information about the Certificate or needs assistance in resolving complaints, he may contact the Company at [insert number].

TABLE OF CONTENTS

SCHEDULE OF BENEFITS FOR COVERED PERSON[#]

[SCHEDULE OF BENEFITS FOR DEPENDENTS{#}]

GENERAL DEFINITIONS[#]

CERTIFICATE GENERAL PROVISIONS[#]

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE
AND TERMINATION PROVISIONS.....[#]

[DEPENDENT ELIGIBILITY, EFFECTIVE DATE
AND TERMINATION PROVISIONS.....{#}]

LIFE INSURANCE BENEFIT FOR COVERED PERSON[#]

TOTAL DISABILITY FOR COVERED PERSON[#]

[ACCELERATED DEATH BENEFIT FOR
COVERED PERSON [AND DEPENDENT SPOUSE]].....[#]

[LIFE INSURANCE BENEFIT FOR DEPENDENTS ...{#}]

TELEPHONIC GRIEF COUNSELING AND SUPPORT SERVICES.....[#]

CLAIMS DETERMINATION/APPEALS PROCEDURE[#]

[PORTABILITY PRIVILEGE FOR {BASIC} {AND} {SUPPLEMENTAL} LIFE
INSURANCE FOR COVERED PERSON {AND {DEPENDENTS}{#}]

[COVERED PERSON CONVERSION{#}]

[DEPENDENT CONVERSION{#}]

[ACCIDENTAL DEATH AND DISMEMBERMENT (“AD & D”) BENEFIT]...{#}]

[EDUCATION BENEFIT FOR QUALIFIED CHILDREN]{#}]

[REPATRIATION BENEFIT FOR COVERED PERSON {AND AD & D
DEPENDENT}}{#}]

SCHEDULE OF BENEFITS FOR COVERED PERSON

This schedule covers the Covered Person whose name is set forth on the first page of the Certificate.

Cost of Insurance: The Covered Person [is] [is not] required to contribute to the cost of his insurance.

Basic Life Insurance Benefit: [\$10,000 - \$400,000][{1-10} times the Covered Person's salary].

Basic Life Insurance Benefit Reduction: Life insurance amounts for the Covered Person will be reduced at age [60 - 80], and will continue to decrease according to the following schedule:

If the Covered Person is Age:	His Insurance Amounts Will Be:
[60 - 80]	[0-100%] of the Covered Person's life benefit
[60 - 80]	[0-100%] of the Covered Person's life benefit
[60 - 80]	[0-100%] of the Covered Person's life benefit
[80 and over]	[0-100%] of the Covered Person's life benefit

Reductions are based on the amount of life insurance in force on the day prior to the first day of the month in which the Covered Person attains age [60-80].

The reduction will take effect on the [date] [first day of the calendar month in which] the Covered Person attains age [60-80].

[Accelerated Death Benefit: The accelerated death benefit is equal to [25-75%] of the basic life insurance in force minus [\$0 - \$25,000]; provided, however, that the maximum amount payable shall be [\$0 - 400,000]. The Covered Person must have at least [\$10,000 - \$50,000] in basic life insurance in force to qualify for this benefit.]

[Supplemental Life Insurance Benefit: {\$0 - 2,000,000}.]

[Supplemental Life Insurance Benefit Reduction: Supplemental life insurance amounts for the Covered Person will be reduced at age {60-80}, and will continue to decrease according to the following schedule:]

[If the Covered Person is Age:	His Insurance Amounts Will Be:
{ 60 - 80 }	{0-100% } of the Covered Person's supplemental life benefit
{ 60 - 80 }	{0-100% } of the Covered Person's supplemental life benefit
{ 60 - 80 }	{0-100% } of the Covered Person's supplemental life benefit
{ 80 and over }	{0-100% } of the Covered Person's supplemental life benefit]

[**SCHEDULE OF BENEFITS FOR DEPENDENT {SPOUSE} {AND} {CHILD}**]

[**Basic Life Insurance Benefit:**

{ Spouse }	{ \$5,000 - \$500,000 }
{ Dependent children (ages { 0 days - 6 months } to { 0 days - 6 months }) }	{ \$100 - \$2,000 }
{ Dependent children ({ 0 days to 6 months } and older) }	{ \$2,000 - \$100,000 }

[The aggregate dependent life insurance coverage for {children} {and} {Spouses} cannot exceed {25-75%} of the Covered Person's basic life insurance benefit.]

[**Basic Life Insurance Benefit Reduction:** Basic life insurance amounts for the Dependent Spouse will be reduced at age {60-80}, and will continue to decrease according to the following schedule:]

[If the Dependent Spouse is Age:	[His Insurance Amounts Will Be:
{ 60 - 80 }	{ 0-100% } of the Dependent Spouse's basic life benefit
{ 60 - 80 }	{ 0-100% } of the Dependent Spouse's basic life benefit
{ 60 - 80 }	{ 0-100% } of the Dependent Spouse's basic life benefit
{ 80 and over }	{ 0-100% } of the Dependent Spouse's basic life benefit]

[Reductions are based on the basic life insurance in force on the day prior to the first day of the month in which the Dependent Spouse attains age {60-80}. The reduction will take effect on the {date} {first day of the calendar month in which} the Dependent Spouse attains age {60-80}.]

[**Accelerated Dependent Spouse Death Benefit:** The accelerated death benefit is equal to [25-75%] of the basic life insurance in force minus {\$0 - \$25,000} {; provided, however, that the maximum amount payable shall be {\$0 - 400,000}}. The Dependent Spouse must have at least {\$10,000 - \$50,000} in basic life insurance in force to qualify for this benefit.]

[Supplemental Life Insurance Benefit for Dependent Spouse: {0 - 2,000,000}.]

[Supplemental Life Insurance Benefit Reduction: Supplemental life insurance amounts for the Dependent Spouse will be reduced at age {60-80}, and will continue to decrease according to the following schedule:]

[If the Dependent His Insurance Amounts Will Be:

Spouse is Age:

{ 60 - 80 }	{0-100% } of the Dependent Spouse's supplemental life benefit
{ 60 - 80 }	{0-100% } of the Dependent Spouse's supplemental life benefit
{ 60 - 80 }	{0-100% } of the Dependent Spouse's supplemental life benefit
{ 80 and over }	{0-100% } of the Dependent Spouse's supplemental life benefit]

GENERAL DEFINITIONS

The male pronoun, whenever used in the Certificate, includes the female.

1. **Active Work or Actively at Work:** An employee of the Policyholder who reports for work at his usual place of employment (including telecommuting) or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The employee must be working at least [10-40] hours per week as an Eligible Employee. The employee will be considered Actively at Work on the following days:

- a) a Saturday, Sunday or holiday which is not a scheduled workday;
- b) a paid vacation day, or other scheduled or unscheduled non-workday; or
- c) an excused or emergency leave of absence (except family or medical leave).

2. **Adverse Benefit Determination:** Includes (i) a denial of a claim, (ii) reduction of a claim, (iii) termination of the Policy (in whole or in part) or (iv) a failure by the Company to provide or make payment (in whole or in part) for a service, supply or benefit under the Policy.

3. **Annual Enrollment Period:** One calendar year after the Policy Effective Date and each year thereafter during the term of the Policy.

4. **Covered Person:** The Eligible Employee (as defined below) insured under the Policy.

5. **[Dependent:** {The Spouse of the Covered Person} {or} {an unmarried child of the Covered Person or the Covered Person's Spouse including:

- {Children at least fourteen (14) days old but under age nineteen (19) who are either the birth children of the Covered Person or the Covered Person's Spouse or legally adopted by or placed for adoption or foster care with the Covered Person or Covered Person's Spouse;}
- {Children at least fourteen (14) days old but under age nineteen (19) for whom the Covered Person or the Covered Person's Spouse is the court appointed legal guardian;}
- {Children age nineteen (19) or older who are either the birth, adopted or foster children of the Covered Person or the Covered Person's Spouse, who are mentally or physically incapable of earning a living and who are chiefly dependent upon the Covered Person for support and maintenance; provided, however, that (i) the onset of such incapacity occurred before age nineteen (19); and (ii) proof of such incapacity is furnished to the Company by the Covered Person upon enrollment of the person as a Dependent child or within thirty-one (31) days of the Dependent child's reaching age nineteen (19) and annually thereafter; and}

- {Children under the age of 25, or the age specified by the Policyholder, who are either the birth or adopted children of the Covered Person, and are attending, on a full-time basis, an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program; provided, however, that the Covered Person provides documentation of such attendance to the Company upon request, and at least twice annually. Coverage ends the last day of the month in which the Dependent child attains the age of 25 or is no longer enrolled in school on a full-time basis. The Covered Person must advise the Company within thirty-one (31) days of the student's loss of full-time attendance status.}

6. **[Domestic Partner:** is an unrelated adult of the same or opposite sex of the Covered Person with whom the Covered Person is living in a committed and exclusive long-term relationship, similar to marriage, and in which the partners are jointly responsible for one another's welfare and financial obligations. Both the Covered Person and the individual seeking to qualify as a Domestic Partner must:]

- [Be at least eighteen (18) years of age or older and mentally competent to consent to a contract.]
- [Not be related by blood in a manner that would bar marriage under the laws of the State of _____.]
- [Have a close and committed personal relationship, be each other's sole Domestic Partner, and not be married to or partnered with any other spouse, spouse equivalent or other Domestic Partner.]
- [For at least {0-3} year{s} prior to seeking qualification as a Domestic Partner under the Policy, have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.]
- [Be jointly financially responsible for basic living expenses defined as the cost of food, shelter, and other expenses of maintaining a household.]

[The Policyholder must provide proof to the Company that the Covered Person and the individual seeking Domestic Partner qualification are interdependent. Such proof must include documentation of at least three of the following:]

- [Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property.]
- [Common ownership of a motor vehicle.]
- [Driver's licenses listing a common address.]
- [Joint bank accounts or credit accounts.]
- [Designation by the Covered Person or individual seeking Domestic Partner qualification of the other as the primary beneficiary for life insurance or retirement benefits, or as primary beneficiary under his will.]

- [Assignment of a durable property power of attorney or health care power of attorney by the Covered Person or individual seeking Domestic Partner qualification to the other.]

[The Company may require the Covered Person and the individual seeking Domestic Partner qualification to sign an Affidavit of Domestic Partnership certifying that the Domestic Partnership exists. The individual seeking Domestic Partner qualification will be deemed a Domestic Partner on the earlier of the date on which (i) he meets the requirements of this definition and (i) he and the Covered Person sign the Affidavit of Domestic Partnership if required by the Company.]

7. **Eligible Employee:** Any employee of the Policyholder who meets all eligibility criteria as may be specified by the Policyholder and who is Actively at Work [and who has been Actively at Work for a continuous period of {1-6} month{s}] [and who has been Actively at Work for the continuous period as specified by Policyholder]. An “Eligible Employee” does not include (i) an employee of the Policyholder who is a member of the armed forces on active duty (except for duty of [5 - 31 days] or less for training in the Reserves or National Guard), (ii) directors or partners of the Policyholder who are not otherwise employed by the Policyholder, (iii) consultants, (iv) independent contractors or (v) stockholders of Policyholder who are not employed by the Policyholder.

8. **[Injury:** A bodily injury resulting directly from an accident and independently of all other causes.]

9. **Physician:** A practitioner of the healing arts who is:
 a) duly licensed in the state in which the Treatment is received; and
 b) practicing within the scope of that license.

The term Physician does not include the Covered Person, or the Covered Person’s Spouse, the children, parents, parents-in-law, or siblings of the Covered Person or the Covered Person’s Spouse.

10. **Sickness:** An illness, disease, pregnancy or complication of pregnancy.

11. **Spouse:** the lawful spouse [or Domestic Partner] of the Covered Person.

12. **Total Disability or Totally Disabled:** The Covered Person will be considered Totally Disabled if the Company determines that he is unable to (i) perform each and every duty of his occupation at his usual place of employment and (ii) do the material and substantial duties of any job suited to his education, training or experience.

13. **Totally Disabled Person:** The Covered Person will be considered a Totally Disabled Person if he ceases to be an Eligible Employee as the result of a Total Disability.

14. **Treatment:** consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

CERTIFICATE GENERAL PROVISIONS

1. **Claim Determinations; ERISA Claim Fiduciary:** For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Company is a claims fiduciary with complete authority to review all denied claims for benefits under the Policy. In exercising such fiduciary responsibility, the Company shall have discretionary authority to determine whether and to what extent Eligible Employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under the Policy or any other document incorporated therein. The Company shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. The Company has the right to adopt reasonable policies, procedures, rules, and interpretations of the Policy to promote orderly and efficient administration. Determinations made by the Company pursuant to this reservation of discretion do not prohibit or prevent the Covered Person from seeking judicial review in federal court of the Company's determinations after the Covered Person has exhausted the appeal procedures set forth in the Policy. This reservation of discretion only establishes the scope of review that a federal court will apply when the Covered Person seeks judicial review of the Company's determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions of the Policy's benefits. The federal court will determine the level of discretion that it will accord the Company's determinations. The Policyholder shall be responsible for making reports and disclosures required by ERISA. This includes the creation, the distribution, and the final content of:

- summary plan descriptions;
- summary of material modifications; and
- summary annual reports.

2. **Fraud:** The Company will use all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person knowingly, and with intent to injure, defrauds or deceives the Company, or files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent permitted under state and/or federal law. The Company will pursue all appropriate legal remedies in the event of insurance fraud.

3. **Incontestability:** The Company may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. The Company may use a statement made by the Covered Person relating to his insurability to contest the validity of the Covered Person's insurance under the Policy provided such statement is in writing and made not more than two years after the Certificate Effective Date. [This provision does not affect the Company's right to contest claims made for accidental death or accidental dismemberment benefits.]

4. **Information and Records to be Furnished:** Upon request by the Company and within a reasonable time thereafter, the Covered Person shall furnish any information or records that have a bearing on insurance or that are required to administer the Policy,

including, but not limited, information and records required by the Company to compute premiums and maintain necessary administrative records.

5. **Clerical Error by Policyholder:** Clerical error by the Policyholder will not:
 - a) Affect the amount of insurance which would otherwise be in effect;
 - b) Continue insurance which otherwise would be terminated; or
 - c) Result in the payment of benefits not otherwise payable.

6. **Misstatement of Age:** If the Covered Person's [or a Dependent's] age has been misstated, an equitable adjustment in the premium amount under the Policy may be made to reflect the Covered Person's [or such Dependent's] correct age. Such adjustment will be made in the Company's sole discretion.

7. **Entire Contract:** The provisions of the Policy, each employee enrollment form and all amendments and/or riders attached thereto or endorse thereon on or after the Policy Effective Date are incorporated into and made part of the Certificate. The Certificate, including the Policy, policy application, and any endorsements, riders, amendments or other attachments to the Certificate, Policy or policy application constitutes the entire contract of insurance. No change in the Certificate shall be valid until approved by the Company's executive officer and unless such approval be endorsed hereon. None of the Policyholder, Policyholder's agent or Covered Person has authority to change the Certificate or to waive any of its provisions.

8. **Termination of the Policy by Policyholder:** The Policy and any coverage included thereunder may be terminated by the Policyholder. The Policyholder must notify its employees in writing of such termination [10 - 90] days prior to the date of termination. Such written notice shall include a description of each employee's respective rights upon termination of coverage [, including the right to convert coverage upon termination]. The Company must be given [10 - 90] days prior written notice of termination and such notice must state the effective date of termination.

9. **Amendment:** Except as otherwise provided herein, the Certificate may only be amended upon the written agreement of both parties; provided however, that the Company may unilaterally amend the Certificate at any time by providing the Covered Person with thirty (30) days prior written notice thereof.

10. **Termination of the Policy by the Company:** The Policy may be terminated or modified by the Company if any of the following occurs:
 - a. The Policyholder does not provide the Company with the information it needs to administer the Policy;
 - b. The Policyholder fails to perform any of its obligations that relate to the Policy;
 - c. The Policyholder fails to pay its premium within the grace period; [or]

- d. The Policyholder makes a material misrepresentation to the Company or its agents to obtain and/or maintain the Policy [; or]
- e. [The number of Covered Persons under the Policy decreases to less than 2] [; or]
- f. [The number of Eligible Employees increases or decreases by {5-20%}] [; or]
- g. [If the Policyholder contributes partially towards the cost of insurance and less than 75% of all of the Policyholder's Eligible Employees are participating under the Policy] [; or]
- h. [If the Policyholder contributes in whole towards the cost of insurance and less than 100% of all of the Policyholder's Eligible Employees are participating under the Policy].

If the Company exercises its right to terminate the Policy, it will: (a) provide [10-90] days advanced written notice of termination to the Policyholder; and (b) promptly return any unearned premium paid or the Policyholder will promptly pay any earned premium that has not been paid. Any earned or unearned premium will be determined on a pro rata basis.

**COVERED PERSON ELIGIBILITY, EFFECTIVE DATE
AND TERMINATION PROVISIONS**

1. **Covered Person's Eligibility:** [an Eligible Employee is automatically enrolled in and becomes a Covered Person under the Policy] [an Eligible Employee is eligible for insurance under the Policy] on the latest of the following dates:

- a. The Policy Effective Date; or
- b. The date on which the employee becomes and Eligible Employee.

2. **Enrolling in or Changing Insurance under the Policy:** The Covered Person or Eligible Employee may enroll in or change his insurance only under the following situations:

A. [Upon becoming an Eligible Employee:

- a. If the employee is an Eligible Employee on the Policy Effective Date, he may enroll for insurance within 31 days of the Policy Effective Date. If an Eligible Employee fails to enroll, then he will not be insured under the Policy.
- b. If the employee becomes an Eligible Employee after the Policy Effective Date, he may enroll for insurance within 31 days of becoming an Eligible Employee. If an Eligible Employee fails to enroll, then he will not be insured under the Policy.]

B. [{An Eligible Employee may enroll for insurance within {10-60} days after the Annual Enrollment Period if he is not currently enrolled under the Policy.}
A Covered Person may enroll in or change his insurance within {10-60} days after the Annual Enrollment Period:

- a. {to keep his same insurance under the Policy;}
- b. {to increase his insurance under the Policy;}
- c. {to decrease his insurance under the Policy; or}
- d. {to cancel his insurance under the Policy.}]

[If a Covered Person does not re-enroll in or change his insurance within {10-60} days after the Annual Enrollment period, he will continue to be covered under the Policy he was enrolled in prior to such period.]

C. [A Covered Person {or an Eligible Employee} may enroll in or change his insurance {at any time during the term of the Policy} {within {10-60} days after the Annual Enrollment Period} if he as:

- a. a change in marital status (marriage, divorce, legal separation, annulment) and enrolls for insurance within 31 days of such change; or
- b. a change in the number of Dependents and he enrolls for insurance within 31 days of such change].

D. [An Eligible Employee or Covered Person who does not enroll in or change his insurance pursuant to Sections {A-C} above may do so {at any time during the term of the Policy} {within {10-60} days after the Annual Enrollment Period}; provided, however, that evidence of insurability may be required.]

3. **[Evidence of Insurability for Supplemental Life Insurance:** Evidence of insurability may be required if an Eligible Employee or a Covered Person enrolls in supplemental life insurance:

- a. For himself in an amount greater than {\$50,000 - 3,000,000} {;or}
- b. {For his Dependent Spouse in an amount greater than {\$2,000 - \$3,000,000}}.]

4. **[Rehired Employee:** If the Covered Person ends employment and is rehired within a year, he may be eligible on his date of re-hire for the insurance that he had under the Policy on the date his employment ended.]

5. **Effective Date of Covered Person Insurance:** [An employee of Policyholder is automatically enrolled as a Covered Person and is covered under the Policy effective at 12:01 A.M. Eastern Standard Time on the date on which he becomes an Eligible Employee; provided, however, that (i) the Company is notified by the Policyholder of such Eligible Employee within 31 days of the date on which such employee becomes an Eligible Employee and (ii) the Policyholder and Eligible Employee submit the required enrollment forms, if any, in accordance with the enrollment timeframes as set forth herein.]

[An Eligible Employee of Policyholder is enrolled as a Covered Person and covered under the Policy for those benefits he selects effective at 12:01 A.M. Eastern Standard Time on the date on which the Company approves such enrollment; provided, however, that (i) the Company is notified of such Eligible Employee within 31 days of the date on which such employee becomes and Eligible Employee and (ii) the Policyholder and Eligible Employee submit to the Company the required enrollment forms, if any, in accordance with the enrollment timeframes as set forth herein.]

If an Eligible Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date on which he returns to Active Work. If and Eligible Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled effective date of his insurance.

6. **Nonpayment of Benefits:** No benefit provided to the Covered Person under the Policy will be paid for any loss caused directly or indirectly from:

- a. the Covered Person's suicide occurring within 24 months after the Certificate Effective Date for the Covered Person [; or]

- b. [the Covered Person's suicide occurring within 24 months after the effective date of any benefit amount increase under the Policy or the addition of any benefit under the Policy.]

7. **Effective Date of Change (Increase) in Amount of Insurance:** If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

- a) the first day of the month on or next following the date of the increase, if the Covered Person is Actively at Work on the date of increase;
- b) the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the first day of the month on or next following the date of the increase;
- c) the first day of the month on or next following the date of the increase, if the first day of the month is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day; or
- d) the date of the increase if the Covered Person is on an approved layoff or leave of absence, for reasons other than an Injury.

8. **Effective Date of Change (Decrease) in Amount of Insurance:** If there is a decrease in the amount of the Covered Person's insurance, the decrease will take effect on the first day of the month on or next following the date of the decrease.

9. **Termination of Covered Person Insurance:** The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard Time on the earliest of the following dates:

- a) the last day of the period for which a premium payment is made, if the next payment is not made;
- b) the date the Covered Person ceases to be an Eligible Employee;
- c) the date the Policy terminates, or a specific benefit terminates;
- d) retroactively to the Certificate Effective Date if the Company determines that the Covered Person has made a material misrepresentation to the Company or its agents to obtain and/or maintain the Policy;
- e) the date the Covered Person ceases to be Actively at Work. The Policyholder may deem the Covered Person's employment continued during an approved layoff or leave of absence. In such cases, insurance will not continue for more than one month (or for such period as otherwise required by state law) from the initial date of the layoff or leave;
- f) the date the Covered Person is no longer Actively at Work due to a labor dispute including without limitation strike, work slow down or lockout [; or]
- g) [the last day of the period for which a premium payment is made by the Covered Person to the Policyholder, if the Covered Person contributes

partially towards the cost of insurance and the Covered Person does not make his next premium payment to the Policyholder.]

10. **[Continuity of Insurance:** If an employee is not Actively at Work on the Policy Effective Date, the Company will waive the Active Work requirement under the following conditions:]

- a. [On the Policy Effective Date, the employee is otherwise an Eligible Employee except for meeting the Actively at Work definition; and]
- b. [The employee was insured under the Policyholder's prior group life insurance plan on the day before the Policy Effective Date.]

[The benefit amounts and limits prior to the employee returning to Active Work will be the same as the benefits under the prior group policy. the Company will reduce the amount it pays by any benefit amount still payable under the prior group policy. This coverage will end on the same date the prior group policy would have ended had it remained in force.]

[When an employee returns to Active Work, he will be eligible for insurance under the Policy.]

11. **[When the Covered Person Retires:** {Basic {and supplemental} life insurance coverage ends for the Covered Person and each Dependent when the Covered Person retires.} {The Covered Person's {and each Dependent's} basic {and supplemental} insurance coverage continues after the Covered Person retires, as long as the Covered Person is a retired employee of the Policyholder and he:}

- a) {retired before the Policy Effective Date and was covered under the Policyholder's prior plan for {life insurance} {and} {health care coverage} on the day before he retired}; {or}
- b) {retired {before} {or} {on} {or} {after} the Policy Effective Date; {or}
- c) {(i) is a legal resident of the state of _____, (ii) was covered under the Policy or another plan sponsored by the Policyholder on the day before he retired, (iii) has completed {0-60} years of service as an employee of the Policyholder and (iv) is age {40-80} or over}; {or}
- d) {retires under the Policyholder's IRS-qualified retirement plan.}]

[The Covered Person's amount of basic {and supplemental} life insurance will be reduced {as of the date he retires} {(unless the Covered Person's basic {and supplemental} life insurance has been fully reduced already because of the plan's age reduction rules)} {to \$0 - \$1,000,000}{by 0-100%} {in accordance with the age benefit reduction table set forth above}.]

[Each Dependent's basic {and supplemental} life insurance coverage ends when the Covered Person retires.]

[The maximum amount of basic life insurance for a retired Covered Person is {\$0-\$5,000,000}.]

[The maximum amount of supplemental life insurance for a retired Covered Person is {\$0-\$5,000,000}.]

[The maximum amount of basic life insurance for each Dependent of a retired Covered Person is {\$0-\$5,000,000}.]

[The maximum amount of supplemental life insurance for a Dependent Spouse of a retired Covered Person is {\$0-\$5,000,000}.]

**[DEPENDENT ELIGIBILITY, EFFECTIVE DATE AND
TERMINATION PROVISIONS]**

[A Covered Person's {Spouse} {or} {child} is eligible for Dependent insurance under the Policy if he meets the definition of "Dependent." A Dependent will not be eligible for coverage if he is:

1. eligible for insurance under the Policy as the Covered Person; or
2. a member of the armed forces on active duty, except for duty of {5-31 days} or less for training in the Reserves or National Guard.]

[Effective Date of Dependent Insurance: {A Covered Person's {Spouse} {or} {child} is automatically enrolled as a Dependent and is covered under the Policy effective at 12:01 A.M. Eastern Standard Time on the latest of the following dates: }

1. {the date on which an Eligible Employee becomes a Covered Person ; or}
2. {the date on which such {Spouse} {or} {child} becomes a Dependent. }

{In order for a Covered Person's {Spouse} {or} {child} to be automatically enrolled as a Dependent: }

1. {The Company must be notified by the Policyholder of such Dependent within 31 days of the date on which such {Spouse} {or} {child} becomes a Dependent; and}
2. {the Policyholder, Covered Person and Dependent must submit to the Company the required enrollment forms, if any, in accordance with the enrollment timeframes as set forth herein. }

{A Covered Person's {Spouse} {or} {child} is enrolled as a Dependent and covered under the Policy for those benefits selected by the Covered Person effective at 12:01 A.M. Eastern Standard Time on the date on which the Company approves such enrollment; provided, however, that (i) the Company is notified of such Dependent within 31 days of the date on which such {Spouse} {or} {child} becomes a Dependent and (ii) the Policyholder, Dependent, and Covered Person submit to the Company the required enrollment forms, if any, in accordance with the enrollment timeframes as set forth herein.}]

[Nonpayment of Benefits: No benefit provided to a Dependent under the Policy will be paid for any loss caused directly or indirectly from:]

1. [A Dependent's suicide occurring within 24 months after the effective date of coverage under the Policy for such Dependent {; or}
2. {A Dependent's suicide occurring within 24 months after the effective date of any benefit amount increase under the Policy or the addition of any benefit under the Policy with respect to such Dependent}.]

[Termination of Dependent Coverage: Dependent coverage ends if:]

1. [the Covered Person's insurance is terminated in accordance with the termination provisions of the Policy;]
2. [the Covered Person dies;]
3. [the Covered Person's {Spouse} {or} {child} is no longer a Dependent; or]
4. [A Dependent becomes eligible for comparable benefits under any other policy offered by the Policyholder.]

LIFE INSURANCE BENEFIT FOR COVERED PERSON

Death Benefits: The Company will pay the Covered Person's basic {and supplemental} life insurance benefit amount as set forth in the Schedule of Benefits upon receipt of proof of the Covered Person's death.

Satisfactory Proof of Death: For purposes of making a death benefit claim, a certified death certificate for the Covered Person must be submitted to the Company.

Assignment: Life insurance provided under the Policy may not be assigned.

Beneficiary: The Covered Person's beneficiary will be the person(s) named by the Covered Person in writing to receive any amount of insurance payable as a result of his death.

The Covered Person may name or change a beneficiary by giving the Company written notice at [insert address] on a form acceptable to the Company. The naming or changing of a beneficiary will be effective as of the date notice is provided to the Company; provided, however, that the Company will not be responsible for any beneficiary payment made under the Policy prior to the date of receiving such notice.

If the Covered Person names more than one beneficiary, those who survive will share any payment due under the Policy equally unless the Covered Person specifies otherwise. If there is no named beneficiary living at the time of the Covered Person's death, the Company will pay any amount due in the following order:

1. to his Spouse;
2. to his natural or legally adopted children in equal shares; or
3. to his estate.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to [\$250] to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

Notice of Claim: Written notice of a claim for death must be given to the Company at [insert address] by the Covered Person's beneficiary or representative within [20-60] days of the date of death. If written notice cannot be provided within [20-60] days, it must be given as soon as reasonably possible.

Proof of Claim: Written proof of claim must be filed by the Covered Person's beneficiary or representative within 180 days of the loss. However, if it is not possible to give proof within 180 days, then proof must be given no later than one year after the loss (except in the absence of legal capacity). A "Written Proof of Claim" form is available

from the Policyholder and can be requested from the Company. A certified copy of the death certificate must be submitted along with the form.

Autopsy: In the case of the Covered Person's death, the Company has the right to have an autopsy made unless not allowed by law. the Company will pay the cost of the autopsy.

TOTAL DISABILITY FOR COVERED PERSON

If the Covered Person becomes a Totally Disabled Person, the Company will continue the Totally Disabled Person's basic [and supplemental] life insurance benefit under the Policy if he:

1. becomes Totally Disabled before [age 55 - 65] and on or after the Certificate Effective Date;
2. remains Totally Disabled continuously for at least [6-12] consecutive months; and
3. provides the Company with proof of Total Disability, as may be required by the Company.

Amount of Life Insurance under the Total Disability Benefit: The Totally Disabled Person will be entitled to an amount of life insurance equal to the amount of basic [and supplemental] life insurance under the Policy on the date he becomes Totally Disabled. This amount will be reduced or terminated in accordance with the Schedule of Benefits in effect on the date of Total Disability. All other benefits and coverage under the Policy will be terminated.

Proof of Total Disability: The Totally Disabled Person must give the Company proof of Total Disability no later than [6-9 months] after the date he becomes Totally Disabled. The Company may, at any time, request proof from the Totally Disabled Person that his Total Disability continues, and he must provide the Company such proof within [30-90 days] of such a request. After the Totally Disabled Person has been Totally Disabled for more than two years from the date of Total Disability, the Company will request proof of Total Disability no more than once a year. The Company will provide to the Totally Disabled Person a standard form to be completed for purposes of establishing proof of a Total Disability.

[Waiver of Premium: The Company will waive the Covered Person's basic {and} {supplemental} life insurance premium payment{s} on a monthly basis, beginning the first day of the month after the date on which he has been Totally Disabled for a continuous {9-12} month period. The Company will refund any premium paid under the Policy after that day. The Company will not refund premiums for any period more than {3 months} before the date proof of Total Disability is furnished. The waiver of premium will continue to be effective even if the Policy terminates after the Covered Person becomes Totally Disabled.]

Death While Totally Disabled: If the Covered Person dies while his {basic} {and} {supplemental} life insurance is being continued under the waiver of premium provision above, the Company will pay the amount of basic {and} {supplemental} life insurance under the Policy upon receiving proof (i) of the Covered Person's death and (ii) that Total Disability was continuous from the date it began to the date of death.

Physical Examination and Autopsy: In the case of the Totally Disabled Person's death, the Company has the right to have an autopsy made unless not allowed by law. The Company will pay the cost of the autopsy.

[Evidence of Insurability for Supplemental Life Insurance under the Total Disability Benefit: A Covered Person who no longer qualifies for the waiver of premium benefit because he returns to Active Work will be required to provide evidence of insurability if he applies to increase his supplemental life insurance within less than {10-90} Days of returning to Active Work.]

Termination of the Total Disability Benefit: The Totally Disabled Person will no longer be eligible for the Total Disability Benefit and his basic [and supplemental] life insurance benefit under this section will terminate on the earlier of the following dates:

1. the date the Totally Disabled Person ceases to be Totally Disabled; provided, however, that if he is still eligible for basic [and] [supplemental] life insurance upon returning to Active Work, his basic [and] [supplemental] life insurance may be continued in force if premium payments are resumed.
2. the last day of the 60-day period following the Company's request for proof of Total Disability, if the Totally Disabled Person does not provide the Company such proof or refuses to take a medical exam to establish a new or continuous Total Disability;
3. the date the Totally Disabled Person reaches [age 60 - 65]; [or]
4. the date the Totally Disabled Person is considered to reside outside the United States. The Totally Disabled Person is considered to reside outside the United States if he has been outside the United States at least 6 consecutive months [; or]
5. [the date on which the premium has been waived for {6-12 months}].

**[ACCELERATED DEATH BENEFIT FOR COVERED PERSON [AND
DEPENDENT SPOUSE]]**

[The payment of the accelerated death benefit may be a taxable event for the Covered Person [and Dependent Spouse]. Therefore, the Covered Person [and Dependent Spouse] should seek assistance from his personal tax advisor regarding taxes he may be obligated to pay as the result of claiming the accelerated death benefit.

If the Covered Person [or Dependent Spouse] becomes terminally ill and has a life expectancy of less than [6-12 months], then he may elect to receive the accelerated death benefit amount as described on the Schedule of Benefits. However, an accelerated death benefit payment against the Covered Person's [or Dependent Spouse's] life insurance benefit can only be made once in his lifetime. If the Covered Person [or Dependent Spouse] elects to receive the accelerated death benefit, then his life insurance benefit amount will be reduced by the accelerated death benefit amount paid.

Proof of Terminal Illness: The Covered Person [or Dependent Spouse] must submit to the Company, and the Company must approve, a request of his intention to exercise the accelerated death benefit and written medical evidence signed by a treating Physician that the Covered Person [or Dependent Spouse]:

1. is under a Physician's care for Treatment of a terminal illness; and
2. has a life expectancy of less than [6-12 months].

Physical Examination and Autopsy: The Company has the right to have a Physician of its choice examine the Covered Person [or Dependent Spouse] as often as reasonably necessary while the claim is pending. The Company may also have an autopsy made in case of death, unless not allowed by law. The Company will pay the cost of the exam and autopsy.

[Limitations: An accelerated death benefit claim will not be payable if:]

1. [The Company has been notified that all or a portion of the life insurance benefits are to be paid to the Covered Person's {or Dependent Spouse's} former spouse as part of a divorce agreement{.} {; or}]
2. [the Covered Person {or Dependent Spouse} is required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement.]]

[LIFE INSURANCE BENEFIT FOR DEPENDENTS]

[Death Benefits: The Company will pay the Dependent's basic {and supplemental} life insurance benefit amount as set forth in the Schedule of Benefits upon receipt of proof of a Dependent's death.

Payment of Claim: Benefits will be paid to:

1. the Covered Person, if living;
2. the Spouse of the Covered Person, if the Covered Person is not living; or
3. the estate of the Dependent, if the Spouse of the Covered Person is not living.

Satisfactory Proof of Death: For purposes of making a death benefit claim, a certified death certificate for the Covered Person must be submitted to the Company.

Notice of Claim: Written notice of a claim for death must be given to the Company at {insert address} by the Covered Person or the Dependent's beneficiary or representative within {20-60 days} of the date of death. If written notice cannot be provided within {20-60 days}, it must be given as soon as reasonably possible.

Proof of Claim: Written proof of claim must be filed by the Covered Person or the Dependent's beneficiary or representative within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than {one year} after the loss (except in the absence of legal capacity). A "Written Proof of Claim" form is available from the Policyholder and can be requested from the Company. A certified copy of the death certificate must be submitted along with the form.

Autopsy: In the case of a Dependent's death, the Company has the right to have an autopsy made unless not allowed by law. The Company will pay the cost of the autopsy.

Assignment: Dependent basic {and supplemental} life insurance provided under the Policy cannot be assigned.]

[TELEPHONIC GRIEF COUNSELING AND SUPPORT SERVICES]

[The Company is affiliated with MHNNet Specialty Services, LLC (“MHNNet”) and offers beneficiaries who have experienced the loss of a Covered Person [or Dependent] access to the MHNNet Life Assistance for Survivors program. This program provides beneficiaries with the following post-loss services:

- Grief Counseling: Access to clinicians with grief counseling experience who provide unlimited telephonic counseling, 24 hours a day/7 days a week, to beneficiaries for up to 180 days after a death.
- Legal Services: One (1) initial 30-minute office or telephone consultation at no cost with a network attorney.
- Financial Services: A telephonic consultation with financial counselors at no cost but limited to 30 minutes per issue.
- Enhanced Self-Help Website: Access to this website featuring an extensive online care library, on-line streaming videos on coping with the loss of a loved one, and financial calculators to assist with budgeting and evaluating current and future financial situations.

The Company will provide the beneficiary access to the MHNNet Life Assistance for Survivors program upon submission of claim under the Certificate.]

CLAIMS DETERMINATION/APPEALS PROCEDURE

CLAIM DETERMINATIONS

The Covered Person [, the Dependent] or a beneficiary, as applicable, may bring a claim under the Policy or appeal any Adverse Benefit Determination. An authorized representative may bring a claim under the Policy or appeal any Adverse Benefit Determination on behalf of the Covered Person [, the Dependent] or the beneficiary, as applicable, provided the Covered Person [, the Dependent] or the beneficiary, as applicable, provides written consent to the Company.

The Company will notify the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, as soon as possible but not later than 30 calendar days after the claim is made. The Company will provide written acknowledgement of receipt of proof of loss within [15-30] days after such proof of loss is received. The Company will also request any additional information in such written acknowledgement. The Company may determine that, due to matters beyond its control, an extension of the 30 calendar day claim determination period is required. If such a determination is made, the Company may extend the determination period for not longer than an additional [30-60] calendar days; provided, however, that the Company notifies the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, of the extension within the first 30 calendar day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Within time frames set forth above, the Company will either provide the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, with:

- the claim settlement and an explanation of benefits; or
- with a denial of the claim in writing with (i) an explanation of the reason(s) for the denial; (ii) reference to the specific plan provision that is the basis for the denial; (iii) a description of any material or information necessary for the Company's review which the Company did not receive and an explanation of why such information is necessary; and (iv) a description of the Company's appeals process (set forth below) and the time limits applicable to such process.

If recalculation or revisitation of a claim becomes necessary subsequent to either denial or settlement, the Company will again comply with the initial claim handling process requirements.

COMPLAINTS

If the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, is dissatisfied with the services received under the Policy, he must submit a complaint, [either] [orally] [or] [in writing], to the Company at [insert address] within [30-60] calendar days, or as soon as reasonably possible, of the incident. A detailed description of the complaint and copies of any records or documents that are relevant to the complaint must also be submitted. The Company will review the information and provide a written response within [15-60] calendar days of the receipt of the complaint, unless additional information is needed and

it cannot be obtained within this period. The notice of the decision will provide instruction for pursuing additional review of the complaint.

Appeals of Adverse Benefit Determinations

The Covered Person [, the Dependent] or the beneficiary or representative, as applicable, may submit an appeal if the Company gives notice of an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination must be submitted within [30-90] calendar days following the receipt of notice of such determination. An appeal [must][may] be submitted [orally or] in writing and should include:

1. The Covered Person's [, the Dependent's] or the beneficiary's or representative's name, as applicable;
2. Policyholder's name;
3. A copy of the Company's notice of an Adverse Benefit Determination;
4. An explanation of reasons supporting the appeal; and
5. Any other information the Company should consider in connection with the appeal (the Company does not require additional information for purposes of reviewing a claims decision).

[Appeals may be sent to the Company at {insert address} {, or can be called in using the following toll-free telephone number {insert phone number}}].

[Appeals should be sent to the address shown on the notice of Adverse Benefit Determination, or can be called in using the toll-free telephone number listed on such notice.]

Appeal

The Company shall issue a decision within [30-60] calendar days of receipt of the request for an appeal. If the Company determines that due to special circumstances an extension of time for claim processing is required, the Company may further extend the determination period for not longer than an additional [30-60] calendar days; provided, however, that the Company notifies the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, of the extension within the first [30-60] calendar day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Within the time frames set forth above, the Company will either provide the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, with:

- the claim settlement and an explanation of benefits; or
- a denial of the claim in writing with (i) an explanation of the reason(s) for the denial; (ii) reference to the specific plan provision that is the basis for the denial; (iii) a statement that the Covered Person [, the Dependent] or the beneficiary or representative, as applicable, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents records, and other

information relevant to Adverse Benefit Determination or appeal, as applicable; and (iv) a statement that if a Covered Person [, Dependent] or beneficiary is a participant or beneficiary of an employee welfare benefit plan under the Federal Employee Retirement Income Security Act (“ERISA”), then he may have the right to bring a civil action under ERISA Section 502(a) after completing the Company appeal process described above.

If recalculation/revisitation of a claim becomes necessary subsequent to either denial or settlement, the Company will again comply with the initial appeal handling process requirements.

The Covered Person [, the Dependent] or the beneficiary or representative, as applicable, shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents records, and other information relevant to Adverse Benefit Determination or appeal, as applicable.

Exhaustion of Process

The [insert name of state insurance regulatory agency] may be contacted to request an investigation of a [complaint or] appeal or to file a [complaint or] appeal with the [insert name of state insurance regulatory agency]. The appeals procedure under the Policy must be exhausted before any litigation or administrative proceeding is commenced with respect to an alleged breach of the Policy by the Company or any other matter within the scope of the appeals procedure.

ERISA Rights

If the Covered Person [, Dependent] or beneficiary is a participant or beneficiary of an employee welfare benefit plan under the Federal Employee Retirement Income Security Act (“ERISA”), the Covered Person [, the Dependent] or a beneficiary or representative, as applicable, may have the right to bring a civil action under ERISA Section 502(a) after completing the Company Appeal process described above. Please see the Policyholder’s Summary Plan Document for a complete statement of any ERISA rights a Covered Person [, Dependent] or beneficiary may have.

**[PORTABILITY PRIVILEGE FOR {BASIC} {AND} {SUPPLEMENTAL} LIFE
INSURANCE FOR COVERED PERSON {AND} {DEPENDENTS}]**

[The Covered Person may not elect to port his insurance under the Policy unless the Covered Person has been insured by the Policy, or the one it replaced, for at least {twelve} consecutive months prior to the date the Covered Person's insurance under the Policy ends..]

[The Covered Person may elect to continue all or part of his {or an insured Dependent child's or Spouse's} basic {and supplemental} life insurance benefit{s} by electing a portable certificate of insurance, subject to the following terms and restrictions.]

[The Covered Person may "port" his insurance if the insurance under the Policy ends for any reason other than:]

1. [termination of employment due to Sickness or Injury;]
2. [failure to pay any required premium;]
3. [termination of the Policy;]
4. [attainment of age {60-75}; or]
5. [termination of the Policyholder as an enrolling group.]

[The Covered Person may not port his insurance{, or insurance for any of his insured Dependents,} if the Covered Person has reached his {60th-75th} birthday on the day the Covered Person's insurance under the Policy terminates.]

[The Covered Person may port the full amount of his basic {and supplemental} life insurance benefit amount{s} as of the day insurance under the Policy terminates.]

[The maximum amount that a Covered Person is eligible to port for all insurances combined is the lesser of the Covered Person's insurance under the Policy or {\$100,000 - \$1,000,000}.]

[The Covered Person may port the full amount of his insured Dependent Spouse's basic {and supplemental} life insurance benefit amount[s], if the Dependent Spouse is insured for an amount under the Policy at least equal to {\$1,000 - \$20,000}. If the Covered Person ports an amount of his basic {and supplemental} life insurance benefit, then any Dependent Spouse amount{s} ported must equal the same percentage as the amount the Covered Person elects port. The maximum Dependent Spouse amount that a Covered Person is eligible to port for all Dependent Spouse insurances combined is the lesser of the Dependent Spouse's insurance under the Policy or {\$50,000 -\$400,000}.]

[The Covered Person may port the full amount of his insured Dependent child's basic {and supplemental} life insurance benefit amount{s}, if the Dependent child's basic {and supplemental} life insurance benefit amount{s}, under the Policy {is} {are} at least {\$2,000}.]

[The Covered Person may port:

1. {his basic life insurance benefit amount only;}
2. {his basic life insurance benefit amount and his insured Dependent Spouse's basic life insurance benefit amount;}
3. {his basic life insurance benefit amount and the basic life insurance benefit amounts of all insured Dependents;}
4. {if the Covered Person is a single parent, his basic life insurance benefit amount and the basic life insurance benefit amounts of all of his insured Dependent children;}
5. {his basic life and supplemental insurance benefit amounts;}
6. {his basic life and supplemental insurance benefit amounts and his insured Dependent Spouse's basic life and supplemental insurance benefit amounts;}
7. {his basic life and supplemental insurance benefit amounts and the basic life and supplemental insurance benefit amounts of all insured Dependents;}
8. {if the Covered Person is a single parent, his basic life and supplemental insurance benefit amounts and the basic life and supplemental insurance benefit amounts of all of his insured Dependent children;}

No other combinations of ported insurance amounts will be allowed.]

[If the Covered Person dies and has basic life {and supplemental} insurance for his Dependent {Spouse} {or} {children}, each of the Covered Person's then-insured Dependents may port their basic life {and supplemental} insurance amount(s). {The maximum amount that a Dependent Spouse is eligible to port for all Dependent Spouse insurances combined is the lesser of the Dependent Spouse's insurance under the Policy or {\$100,000 - \$1,000,000}.} {The maximum amount that a Dependent child is eligible to port is the lesser of the Dependent child's insurances combined under the Policy or {\$100,000 - \$1,000,000}.} {The Covered Person's then-insured surviving Dependent Spouse must port in order for the Covered Person's then-insured surviving Dependent children to port. If there is no surviving Dependent Spouse, then no Dependent children will be allowed to port}].

[The Covered Person {and insured Dependents} can port to a portable certificate of insurance. The certificate of insurance:

- will provide term group life insurance;
- will not provide for a waiver of premium benefit for Total Disability;
- may not provide benefits identical to the benefits provided by the Policy.]

[The Covered Person {or insured Dependents} must send a written request to the Company for a portable certificate of insurance no later than 31 days after the Covered Person's {or such Dependent's} coverage under the Policy terminates. Upon receipt of such notice the Company will provide the necessary application materials required to issue the certificate

of portability. Upon approval by the Company of the completed application materials and payment by {Covered Person} {and/or} {Dependent} {and/or} {Policyholder} of the required premium, the Company will issue the certificate of portable coverage.]

[No Covered Person is allowed to convert his insurance and elect a portable certificate of insurance at the same time. If a situation arises in which a Covered Person would be eligible to both convert and port, he may only exercise one of these privileges. The Covered Person may never be insured under both a converted policy and a portable certificate of insurance at the same time.]

[Employees rehired after porting insurance must either lapse the ported insurance or provide evidence of insurability to keep the ported insurance.]

[COVERED PERSON CONVERSION]

[The Covered Person may convert to an individual life insurance policy:]

1. [in an amount equal to all or part of his life insurance benefit under the Policy if his insurance is terminated because he ceases to be a an Eligible Employee;]
2. [in an amount equal to the amount of life insurance benefit that is lost due to a reduction of insurance because of age; or]
3. [if he has been continuously insured under the Policy for five years and the life insurance benefit terminated due to termination or amendment of the Policy. The amount of life insurance the Covered Person may convert is the smaller of the following:]
 - a. [the amount of life insurance under the Policy which terminates, less the amount he becomes eligible for under any other policy within {31-60 days} after such termination; or]
 - b. [{\$2,000 - 100,000.}]

[The Covered Person may convert to a permanent life insurance policy that the Company is issuing at such time for the purpose of conversions. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The Covered Person must submit a written application and the first premium payment for the conversion policy to {insert address} within {31-60 days} after his insurance terminates. It is the Covered Person's responsibility to pay the premiums for the conversion policy. The premium will be based on the amount and the form of the conversion policy, and on his class of risk and age on the date the conversion takes effect. The Covered Person may not convert a Policy under this Section if he qualifies for the Total Disability benefit under the Policy.]

[If the Covered Person dies within the {31-60 days} allowed for making an application to convert, the Company will pay the amount he would have been entitled to convert. The Company will make such payment whether or not an application was made by the Covered Person.]

[Amounts of insurance that the Covered Person has ported will not be eligible for the conversion under this Section unless the certificate of portability is returned.]

[The conversion policy will take effect on the later of:]

1. [its date of issue; or]
2. [{31-60 days} after the date the Covered Person's insurance terminates under the Policy.]

[The life insurance benefit under the Policy may be reinstated within one year after termination of employment if the Covered Person has converted and he:]

1. [gives the Company proof that he was Totally Disabled when his life insurance terminated under the Policy and that his life insurance would have continued in force under the Total Disability benefit if he had not converted; and]
2. [surrenders the conversion policy to the Company without claim in return for premiums paid less any unpaid policy loans.]

[Employees rehired after converting to an individual life insurance policy must either terminate such policy or provide evidence of insurability to keep the policy.]

[DEPENDENT CONVERSION]

[An insured Dependent may convert all or part of his life insurance benefit under the Policy to an individual life policy if his life insurance benefit under the Policy terminates because:]

1. [the Covered Person ceases to be an Eligible Employee;]
2. [with respect to a Dependent Spouse only, the amount of the life insurance benefit under the Policy for the Dependent Spouse has been reduced because of age;]
3. [the Covered Person becomes Totally Disabled or dies;]
4. [the Dependent is no longer eligible for the Dependent life insurance benefit; or]
5. [of the termination or amendment of the Policy; provided, however, that the Dependent has been continuously insured under the Policy for five years.]

[The amount the Dependent may convert in this case is the smaller of the following:]

1. [the amount of his life insurance under the Policy which terminates, less the amount he becomes eligible for under any other policy within {31-60 days} after such termination; or]
2. [{\$1,000}.]

[The Dependent may convert to a permanent life insurance policy that the Company is issuing at such time for the purpose of conversions. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The Dependent must submit a written application and the first premium payment for the conversion policy to {insert address} within {31-60 days} after his insurance terminates. It is the Dependent's responsibility to pay the premiums for the conversion policy. The premium will be based on the amount and the form of the conversion policy, and on his class of risk and age on the date the conversion takes effect. The Dependent may not convert a Policy under this Section if he qualifies for coverage under any other life insurance policy.]

[If the Dependent dies within the {31-60 days} allowed for making an application to convert, the Company will pay the amount he would have been entitled to convert. The Company will make such payment whether or not an application was made by the Dependent.]

[Amounts of insurance that the Dependent has ported will not be eligible for the conversion under this Section unless the certificate of portability is returned.]

[The conversion policy will take effect on the later of:]

1. [its date of issue; or]
2. [{31-60 days} after the date the Dependent's insurance terminates under the Policy.]

[ACCIDENTAL DEATH AND DISMEMBERMENT (“AD & D”) BENEFIT]

[For purposes of this section:]

[“**Air Bag**” means a supplemental restraint system that inflates for added protection to the head and chest areas. The Air Bag must meet published federal safety standards, be installed by the car manufacturer or consist of proper replacement parts as required by the car manufacturer’s specifications and not have been altered after such installation.]

[“**Passenger Car**” means any validly registered four-wheel private passenger car or motor vehicle.]

[“**Seat Belt**” means any restraint device which meets published federal safety standards, has been installed by the car manufacturer or reinstalled according to the manufacturer’s specifications and has not been altered after such installation.]

[If the Covered Person {or the Covered Person’s Dependent {Spouse} {or} {child} ({each, an}{the} “AD & D Dependent”)} suffers one or more of the following losses or injuries (each an “AD & D Loss”), the Company will pay the percentage of the Covered Person’s {or}{AD & D Dependent’s} total life insurance benefit under the Policy that corresponds with each loss or injury:]

[Loss of thumb and index finger of the same hand through or above the joint closest to the wrist	25%
Loss of one hand by severance at or above the wrist	50%
Loss of one foot by severance at or above the ankle	50%
Irrecoverable loss of the sight in one eye resulting in legal blindness	50%
Any combination of two or more of the losses listed above	100%
Loss of life	100%]

[**Basic AD & D Benefit Reduction:** AD & D insurance amounts for the Covered Person {and Dependent Spouse} will be reduced at age {60-80}, and will continue to decrease according to the following schedule:]

[If the Covered Person {or Dependent Spouse} is Age:	His Insurance Amounts Will Be:
{60 - 80}	{0-100% } of the Covered Person’s {or Dependent Spouse’s} AD & D Benefit

{ 60 - 80 }	{0-100% } of the Covered Person's Dependent Spouse's } AD & D Benefit	{ or
{ 60 - 80 }	{0-100% } of the Covered Person's Dependent Spouse's } AD & D Benefit	{ or
{ 80 and over }	{0-100% } of the Covered Person's Dependent Spouse's } AD & D Benefit]	{ or

[Reductions are based on the AD & D insurance in force on the day prior to the first day of the month in which the Covered Person {or Dependent Spouse} attains age {60-80}. The reduction will take effect on the {date} {first day of the calendar month in which} Covered Person {or Dependent Spouse} attains age {60-80}.]

[The Covered Person {or the AD & D Dependent}, or the Covered Person's {or AD & D Dependent's} beneficiary, must give the Company proof that the AD & D Loss:]

1. [Occurred while the AD & D benefit was in force under the Policy;]
2. [Occurred within {60-180 days} after an Injury; and]
3. [Was due to an Injury.]

[In paying the AD & D benefit, the Company will consider only AD & D Losses sustained by the Covered Person {or AD & D Dependent} while insured under the AD & D section of the Policy. The Company will pay no more than the full AD & D benefit amount shown in the Schedule of Benefits for any AD & D Loss or Losses resulting from any Injury or Injuries.]

[The Company will pay an additional benefit for the loss of the Covered Person's {or the AD & D Dependent's} life while insured under the Policy resulting from injuries sustained while driving or riding in a private Passenger Car if the Covered Person's {or the AD & D Dependent's} Seat Belt was properly fastened. A police report or other evidence must establish the correct position and fastening of the Seat Belt. A copy of the police report must be submitted with the claim.]

[The Seat Belt benefit is not payable if:

1. The Covered Person {or the AD & D Dependent} is either a driver or passenger, and the driver was legally intoxicated or under the influence of drugs at the time of the accident; or
2. The driver of the private Passenger Car does not hold a current and valid driver's license at the time of the accident.]

[The Company will pay an additional Air Bag Benefit for the loss of the Covered Person's {or the AD & D Dependent's} life while insured under the Policy resulting from injuries sustained while driving or riding in a private Passenger Car if the Seat Belt benefit is payable and the conditions regarding Air Bag Benefit set forth in this paragraph are satisfied. A police report or other evidence must establish the proper inflation of the Air Bag upon impact. The Air Bag Benefit is only payable if:]

1. [the private Passenger Car is equipped with a single Air Bag for the driver seat and the Covered Person{or the AD & D Dependent}is the driver;
2. the private Passenger Car is equipped with an Air Bag for both the driver and front passenger seat and the Covered Person{or the AD & D Dependent}is either the driver or front seat passenger; or
3. the private Passenger Car is equipped with an Air Bag for the driver seat, front passenger seat and all rear passenger seats and the Covered Person{or the AD & D Dependent}is a driver, front seat passenger or rear seat passenger.]

[The Company will pay the Seat Belt and Air Bag benefits as follows:]

1. [A Seat Belt benefit {of \$1,000-\$10,000} {in an amount equal to {1-4% } of the full amount of the AD & D benefit}; or
2. A Seat Belt and Air Bag Benefit {of \$1,000-\$20,000} {in an amount equal to {1-8% } of the full amount of the AD & D benefit}.]

[However, the amount payable will not exceed {\$1,000-\$10,000} for the Seat Belt Benefit or {\$1,000 - \$20,000} for the combined Seat Belt and Air Bag Benefit.]

[AD & D Limitations: The Company will not pay an AD & D benefit for an AD & D Loss caused directly or indirectly by:]

1. [disease, bodily or mental infirmity or medical or surgical Treatment therefore;
2. [suicide or intentionally self-inflicted Injury, regardless of psychological disposition;]
3. [participation in a riot or insurrection, or commission of an assault or felony;]
4. [war or any act of war, declared or undeclared;]
5. [use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;]
6. [intoxication (which means that blood alcohol content or the results of other means of testing alcohol meet or exceed the legal presumption of intoxication as defined by the jurisdiction in which the AD & D Loss occurs);]
7. [engaging in hazardous activities including but not limited to skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles;]
8. [travel or flight in, or descent from, any aircraft {, except if {(a) employment duties require the Covered Person {or the AD & D Dependent} to be a pilot and/or passenger in a privately owned aircraft} {,or} {(b)} the Covered Person {or the AD & D Dependent} is a fare-paying passenger on a commercial airline flying between established airports on (i) a scheduled route or (ii) a charter flight seating 15 or more people}.}]

[Notice of Claim: Written notice of an AD & D claim must be given to the Company at

[insert address] by the Covered Person {or the AD & D Dependent}, or his beneficiary or representative within {30-90 days} of the date of death or Injury, as applicable. If written notice cannot be provided within {30-90 days}, it must be given as soon as reasonably possible.]

[Proof of Claim: Written proof of the claim must be filed by the Covered Person {or the AD & D Dependent}, or his beneficiary or representative within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the loss (except in the absence of legal capacity). A “Written Proof of Claim” form is available from the Policyholder and can be requested from the Company. If the claim is for a death benefit, a certified copy of the death certificate must be submitted along with the form.]

[Physical Examination and Autopsy: The Company has the right to have a Physician of its choice examine the Covered Person {or AD & D Dependent} as often as reasonably necessary while the claim is pending. The Company may also have an autopsy made in case of death, unless not allowed by law. The Company will pay the cost of the exam and autopsy.]

[Assignment: The AD & D insurance provided under the Policy cannot be assigned.]

[When the Covered Person Retires: {AD & D insurance coverage ends for the Covered Person and each Dependent when the Covered Person retires.} {The Covered Person’s {and each Dependent’s} AD & D insurance coverage continues after the Covered Person retires, as long as the Covered Person is a retired employee of the Policyholder and he:}

- {retired before the Policy Effective Date and was covered under the Policyholder’s prior plan for {life insurance} {and} {health care coverage} on the day before he retired}; {or}
- {retired {before} {or} {on} {or} {after} the Policy Effective Date; {or}
- {(i) is a legal resident of the state of _____, (ii) was covered under the Policy or another plan sponsored by the Policyholder on the day before he retired, (iii) has completed {0-60} years of service as an employee of the Policyholder and (iv) is age {40-80} or over}; {or}
- {retires under the Policyholder’s IRS-qualified retirement plan.}]

[The Covered Person’s amount AD & D insurance will be reduced {as of the date he retires} {(unless the Covered Person’s AD & D insurance has been fully reduced already because of the plan’s age reduction rules)} {to \$0 - \$1,000,000}{by 0-100%} {in accordance with the age benefit reduction table set forth above}.]

[Each Dependent’s Basic AD & D insurance ends when the Covered Person retires.]

[The maximum amount of AD & D insurance for a retired Covered Person is {\$0-\$5,000,000}.]

[The maximum amount of AD & D insurance for each retired Covered Person's Dependent is {\$0-\$5,000,000}.]

[EDUCATION BENEFIT FOR QUALIFIED CHILDREN]

[For purposes of this section, “**Qualified Child**” means the Covered Person’s unmarried Dependent child age {17-30} or under who, on the date of the Covered Person’s death, is either:]

1. [enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or]
2. [currently enrolled in a secondary school at the 12th grade level and, within 365 days following the date of the Covered Person's death, enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.]

[The Company will pay a yearly education benefit to a Qualified Child if:

1. [the Covered Person’s AD & D benefit is payable under the Policy;]
2. [the Covered Person dies within{60-180 days} after the date of an Injury;]
3. [the Company is provided with proof that the child is a Qualified Child; and]
4. [the Qualified Child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.]

[The maximum yearly education benefit amount is the lesser of:]

1. [{1% - 8%} of the Covered Person's AD & D benefit; or]
2. [{\$1,000 - \$20,000}].]

[The Company will not pay more than an aggregate amount of {\$1,000 - \$20,000} or {1% - 8%} of the Covered Person’s AD & D benefit per year regardless of the number of Qualified Children the Covered Person may have.]

[The education benefit is payable in addition to any other benefits provided under the Policy. The Company will not pay more than one education benefit per Qualified Child during any one school year.]

[The education benefit will terminate for each Qualified Child on the earliest of the following dates:]

1. [the date the Qualified Child ceases to be a Qualified Child;]
2. [the date the Qualified Child fails to furnish proof that he is a Qualified Child as required by the Company;]
3. [the date the Qualified Child no longer qualifies as a Dependent child for any reason; provided, however, that the Company will not consider the Covered Person’s death a disqualification for purposes of determining whether the Qualified Child requirements are met; or]

4. [the earlier of the date on which the 4th education benefit has been paid or the date the Qualified Child completes his fourth year of enrollment in an accredited post-secondary institution.]

[Notice of Claim: Written notice of a claim for the education benefit must be given by the Covered Person's beneficiary or representative to the Company at [insert address] within {30 -90 days} of the date of death. If written notice cannot be provided within {30 -90 days}, it must be given as soon as reasonably possible.]

[Proof of Claim: Written proof of claim must be filed by the Covered Person's beneficiary or representative within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than 1 year after the loss (except in the absence of legal capacity). A "Written Proof of Claim" form is available from the Policyholder and can be requested from the Company. A certified copy of the death certificate and proof that the Dependent child is a Qualified Child must be submitted along with the form.]]

**[REPATRIATION BENEFIT FOR COVERED PERSON {AND AD & D
DEPENDENT}]**

[The Company will pay a repatriation benefit if all of the following requirements are met:]

1. [The Covered Person {or AD & D Dependent} dies as the result of an Injury and the AD & D benefit is payable as a result of such Injury;]
2. [The Covered Person {or AD & D Dependent} death occurs more than {100-1,000} miles from his primary place of residence; and]
3. [Covered Expenses (as defined below) are incurred.]

[The amount of the repatriation benefit is the lesser of:]

1. [the Covered Expenses incurred; or]
2. [{1-10%} of the Covered Person's {or AD & D Dependent's} AD & D benefit; or]
3. [{\$1,000-\$10,000}].

[The repatriation benefit is payable to the person who incurs the expenses.]

["Covered Expenses" means expenses incurred for the preparation and transportation of the Covered Person's {or AD & D Dependent's} body to a mortuary near the primary place of residence, including but not limited to, expenses associated with embalming, cremation, purchasing of a coffin, and transportation of the Covered Person's {or AD & D Dependent's} body.]

[Notice of Claim: Written notice of a claim for the repatriation benefit must be given to the Company at [insert address] within {30-90 days} of the date of death. If written notice cannot be provided within {30-90 days}, it must be given as soon as reasonably possible. Written notice must be given by the Covered Person's {or AD & D Dependent's} beneficiary or representative.]

[Proof of Claim: Written proof of claim must be filed within {30-90 days} of the loss. However, if it is not possible to give proof within {30-90 days}, it must be given no later than 1 year after the loss (except in the absence of legal capacity). A "Written Proof of Claim" form is available from the Policyholder and can be requested from the Company. A certified copy of the death certificate must be submitted along with the form. Written proof of claim must be filed by the Covered Person's {or AD & D Dependent's} beneficiary or representative.]]

Employer Application for Group Term Life Insurance 51 or more Eligible Employees

Life insurance products are underwritten by AmFirst Insurance Company.

PLEASE TYPE OR PRINT LEGIBLY

SECTION I - Employer Information					
* Group Number(s) Include all service areas: (AmFirst Insurance Company Use Only)					
Company Name (the "Company") - include Legal name and any dba's:					Federal Tax ID #
Company Address Street			City State Zip		E-mail address
Administrative Contact (Signatory)			Chief Executive Officer/President/or Owner		
Mailing/Billing Address			Physical Address		
Benefits Contact	Phone #	Fax #	Billing Contact	Phone #	Fax #
# of Years in Business	Standard Industry Code (SIC)	Nature of Business		Corporation Partnership	Sole Proprietor Other _____

SECTION II - Term Life and Accidental Death and Dismemberment Plan Options															
<p>Step One: Define Employee Classifications: Amounts of basic group life insurance should be a uniform percentage of salary or flat amount for each employee. You can select group life insurance based upon employee classifications. If you would like to separate your employee population into classes, please do so here and indicate the benefits each class is to receive by inserting the class number as requested next to the benefit selections in Steps Two through Six below. Note: The classifications must not exceed 2.5 times between each class or 10 times between the lowest and highest class.</p>															
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Class # Definition</td> <td style="width: 50%;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;">1: _____ 3: _____</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black;">2: _____ (No more than 3 classes may be used.)</td> <td></td> </tr> </table>	Class # Definition		1: _____ 3: _____		2: _____ (No more than 3 classes may be used.)		<p>Step Two: By employee class, choose the method determining the basic group term life insurance amount, either Salary Multiple (1x, 1.5x or 2x) or Flat Dollar Amount</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Class ____</td> <td style="width: 50%;">Class ____</td> </tr> <tr> <td><input type="checkbox"/> Flat \$ _____</td> <td><input type="checkbox"/> Flat \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Multiplier _____</td> <td><input type="checkbox"/> Multiplier _____</td> </tr> <tr> <td>Employer Contribution ____</td> <td>Employer Contribution ____</td> </tr> </table>	Class ____	Class ____	<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Multiplier _____	<input type="checkbox"/> Multiplier _____	Employer Contribution ____	Employer Contribution ____
Class # Definition															
1: _____ 3: _____															
2: _____ (No more than 3 classes may be used.)															
Class ____	Class ____														
<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Flat \$ _____														
<input type="checkbox"/> Multiplier _____	<input type="checkbox"/> Multiplier _____														
Employer Contribution ____	Employer Contribution ____														
<p>Step Three: Accidental Death & Dismemberment: Employee (Choose "Yes" if electing to offer Employee Accidental Death & Dismemberment coverage) Yes If yes, class #s _____ No</p>															
<p>Step Four: Dependent Life (Choose "Yes" if electing to offer dependent life coverage) Yes If yes, class #s _____ No</p> <p>If you choose to offer Dependent Life, which option would you like to offer?</p> <p>Fixed coverage: \$5,000 Spouse/\$2,000 Child Class #s _____ Fixed coverage: \$10,000 Spouse/\$5,000 Child Class #s _____ Variable Spouse with Fixed Child: Class #s _____</p> <p>③ Spouse coverage amount selected by employee in \$10,000 increments up to 50% of employee coverage ③ \$2,000 Child</p> <p>Variable Spouse with Fixed Child: Class #s _____ ③ Spouse coverage amount selected by employee in \$10,000 increments up to 50% of employee coverage ③ \$5,000 Child</p>															
<p>Step Five: Accidental Death & Dismemberment: Dependent (Choose "Yes" if electing to offer Dependent Accidental Death & Dismemberment coverage) Yes If yes, class #s _____ No</p>															

AmFirst Insurance Company
Administrative Office:
5722 I-55 North Frontage Rd., Jackson, Mississippi 39211
Telephone 601-956-2028

SECTION II - Term Life and Accidental Death and Dismemberment Plan Options

Step Six: Employee Supplemental Life (Choose "Yes" if electing to offer Employee Supplemental Life coverage)
 Yes If yes, class #s _____
 No

If you choose to offer Employee Supplemental Life coverage, your choice for multiple of salary vs. fixed dollar basic employee life coverage in Step One above will also apply in this category. For example, if you elected fixed coverage, employees will be able to choose supplemental life coverage in \$10,000 increments up to plan maximum. If you elected multiple of salary, employees will be able to choose supplemental life coverage as 1x, 1.5x or 2x salary, up to plan maximum.

Step Seven: Custom coverage is only available for groups with more than 250 eligible employees. If you are electing custom coverages, please indicate them below:

Guaranteed Issue Amounts: Amounts in excess of the guaranteed issue are subject to evidence of insurability. Guaranteed issue amount for groups with 51 eligible employees or greater is \$150,000.

Note: The face amount of all coverages under the Policy are subject to the following age reduction schedule:

Age:	Coverage Reduction
65 to 70	65%
70 to 75	40%
75 to 80	25%
80 and over	20%

SECTION III - Group Underwriting, Enrollment, Eligibility, Continuation and Participation

Employee Eligibility:	Coverage Begins:	Coverage Ends:	Dependent Age Limits:
Full-time employees Actively-at-work _____ hours per week	Date of Hire	End of the month of termination	___/__(student)
Other: (explain)	1 st day of month following waiting period of: _____ days	Date of termination Other: (explain)	

Is this waiting period applied to rehired employees?
 Yes
 No
 Other: (explain)

Note: any responses marked "Other" require approval by AmFirst Insurance Company.

SECTION IV - Employer Statement and Signature

Employer Statement: The Company certifies that the information provided on this document is complete and accurate. The Company shall notify AmFirst Insurance Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the additional of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the Company. All coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees.

AmFirst Insurance Company reserves the right to retroactively adjust the rates provided if information subsequently received indicates information was not complete, inaccurate or a material representation was made in the application, and such information would have materially affected the rate calculation, in accordance with the terms of the Policy. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found.

Acceptance of this Application is subject to final approval by AmFirst Insurance Company and shall be based upon all information supplied by the Company, the requested benefits, and any other information obtained from outside sources which AmFirst Insurance Company deems appropriate. Upon acceptance by AmFirst Insurance Company, this Application shall be attached to and shall become part of the Policy.

AmFirst Insurance Company
Administrative Office:
5722 I-55 North Frontage Rd., Jackson, Mississippi 39211
Telephone 601-956-2028

SECTION IV - Employer Statement and Signature

Fraud Warning:

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law. For the following states, the listed fraud warning applies:

Arkansas

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.

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.

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 fines and confinement in prison.

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.

Oklahoma

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.

Tennessee

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.

Virginia

Any person who, with the 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 may have violated the state law.

Name and Title (print):	Signature:	Date:
--------------------------------	-------------------	--------------

SECTION VI - Broker Information (Complete if producer is not the AmFirst Insurance Company employee)

Broker Name	AmFirst Health Care Broker Number
Department of Insurance License Number/ Indicate State	Broker Commission Split
Agency Name	Broker Phone #
Broker Address	Broker Fax #
Broker Tax ID Number	AmFirst Health Care Account Executive Name

Life Enrollment/Change Form Large Group

*Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment **OR** Change.

A EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: _____		*Group No.: _____	
Date Employed Full Time: _____		*Effective Date of Coverage or Change _____	
Class # _____		REASON FOR ENROLLMENT OR CHANGE	
ENROLL		TERMINATE COVERAGE	
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Group Request	<input type="checkbox"/> Terminate Subscriber	<input type="checkbox"/> Name
<input type="checkbox"/> New Group	<input type="checkbox"/> Member Request	<input type="checkbox"/> Terminate Dependent	<input type="checkbox"/> Address/Phone
<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Event (Reason)	<input type="checkbox"/> Deceased	
<input type="checkbox"/> COBRA	Date: ____/____/____	<input type="checkbox"/> Termination Reason: _____	
<input type="checkbox"/> Add Dependent	**List Reason: _____		

EMPLOYEE STATUS:

Active COBRA Salary Hourly Number of hours a week _____ Other _____

Benefits Administrator Approval: _____ Date: _____

B EMPLOYEE LIFE INSURANCE ELECTIONS¹

I elect the following Life Insurance options for myself: Basic employee group term life coverage

Indicate dollar amount \$ _____ salary multiple _____

Supplemental Employee Life Insurance Elections: Accidental Death and Dismemberment coverage (if offered)

Employee supplemental term life insurance (if offered): Indicate dollar amount \$ _____ salary multiple _____

If you are requesting a total coverage amount in excess of the guaranteed issue amount, you may be required to submit evidence of insurability.

Dependent Life Insurance Elections (if offered):

From the options your employer has chosen to offer, please indicate your elections for your eligible dependents.

Spouse term life coverage amount \$ _____; Child term life coverage amount \$ _____

Dependent Accidental Death and Dismemberment coverage

Type of Coverage : Employee Employee/Spouse Employee/Child Employee/Children Employee/Spouse/Child(ren)

Beneficiary Information The Beneficiary(ies) you list below will apply to your Life and Accidental Death and Dismemberment benefits (if offered). Your beneficiary may be anyone you choose, and you may name more than one beneficiary. When more than one beneficiary is designated, payment will be made in equal shares, unless designated otherwise, to each surviving beneficiary, or the entire amount will be paid to the last survivor. Total percentage of beneficiary allocation must equal 100% and be in whole percentage points.

*Name	*Address	*Relationship	*Percentage Allocated

C LIFE WAIVER (only complete if waiving coverage)

I understand that if I decide to apply for life coverage for myself and any applicable dependent(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.

Waive Life Myself Spouse Dependent(s) **Reason:** Other Insurance Spousal Coverage Other Reason (please explain): _____

Employee Signature (only if you are waiving coverage) _____ Date _____

D EMPLOYEE INFORMATION

*Last Name		*First Name		MI
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		*Birthdate		*Social Security Number
*Address				
*City		*State		*Zip Code
Work Phone			Home Phone	

E FAMILY MEMBERS TO BE COVERED OR DELETED

If address and phone numbers of covered dependents are different from those of policy holder, please attach that information on a separate sheet of paper.

FULL NAME (Last, First MI)		SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	Spouse	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -

F EMPLOYEE SIGNATURE¹Life insurance products are underwritten by AmFirst Insurance Company**Fraud Notice**

Arkansas 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.

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.

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 fines and confinement in prison.

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.

Oklahoma 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.

Tennessee 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.

Virginia Any person who, with the 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 may have violated the state law.

General Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application.

Employee Signature_____
Date

AmFirst Insurance Company
Administrative Office:
5722 I-55 North Frontage Rd., Jackson, Mississippi 39211
Telephone: 601-956-2028

SECTION IV - Employer Statement and Signature

Employer Statement: The Company certifies that the information provided on this document is complete and accurate. The Company shall notify AmFirst Insurance Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the additional of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the Company. All coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees.

AmFirst Insurance Company reserves the right to retroactively adjust the rates provided if information subsequently received indicates information was not complete, inaccurate or a material representation was made in the application, and such information would have materially affected the rate calculation, in accordance with the terms of the Policy. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found.

Acceptance of this Application is subject to final approval by AmFirst Insurance Company and shall be based upon all information supplied by the Company, the requested benefits, and any other information obtained from outside sources which AmFirst Insurance Company deems appropriate. Upon acceptance by AmFirst Insurance Company, this Application shall be attached to and shall become part of the Policy.

Fraud Warning. Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law. For the following states, the listed fraud warning applies:

Arkansas

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.

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.

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 fines and confinement in prison.

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.

Oklahoma

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.

Tennessee

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.

Virginia

Any person who, with the 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 may have violated the state law.

Name and Title (print):	Signature:	Date:

SECTION VI - Broker Information (Complete if producer is not AmFirst Insurance Company employee)

Broker Name	AmFirst Health Care Broker Number
Department of Insurance License Number/ Indicate State	Broker Commission Split
Agency Name	Broker Phone #
Broker Address	Broker Fax #
Broker Tax ID Number	AmFirst Health Care Account Executive Name

Life Enrollment/Change Form Small Group

*Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment OR Change.

A EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: _____ *Group No.: _____
 Date Employed Full Time: _____ *Effective Date of Coverage or Change _____

REASON FOR ENROLLMENT OR CHANGE

ENROLL

- Open Enrollment
- New Group
- New Hire
- COBRA
- Add Dependent
- Group Request
- Member Request
- Qualifying Event (Reason)
Date: ____/____/____
- **List Reason: _____

TERMINATE COVERAGE

- Terminate Subscriber
- Terminate Dependent
- Deceased
- Termination Reason: _____

CHANGE

- Name
- Address/Phone

EMPLOYEE STATUS:

- Active
- COBRA
- Salary
- Hourly
- Number of hours a week _____
- Other _____

Benefits Administrator Approval: _____

Date: _____

B LIFE COVERAGE ELECTION

I ELECT THE FOLLOWING FOR MYSELF AND MY DEPENDENT(S)*: Life¹ *If Dependent Coverage is Offered

Type of Coverage : Employee Employee/Spouse* Employee/Child* Employee/Children* Employee/Spouse/Child(ren)*

Beneficiary Information

*Beneficiary Last Name _____ *First Name _____ MI _____

*Relationship _____ *Address _____

*City _____ *State _____ *Zip Code _____

C LIFE WAIVER (only complete if waiving coverage)

I understand that if I decide to apply for life coverage for myself and any applicable dependent(s) at a later date, neither my dependent(s) nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI.

Waive Life Myself Spouse Dependent(s) Reason: Other Insurance Spousal Coverage Other Reason (please explain): _____

Employee Signature (only if you are waiving coverage) _____

Date _____

D EMPLOYEE INFORMATION

*Last Name _____ *First Name _____ MI _____

*Gender Male Female *Birthdate _____ *Social Security Number _____

*Address _____

*City _____ *State _____ *Zip Code _____

Work Phone _____

Home Phone _____

E FAMILY MEMBERS TO BE COVERED OR DELETED If address and phone numbers of covered dependents are different from those of policy holder, please attach that information on a separate sheet of paper.

	FULL NAME (Last, First MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F	Spouse	/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -
<input type="checkbox"/> Enroll <input type="checkbox"/> Delete		M F		/ /	- -

F EMPLOYEE SIGNATURE

¹Life insurance products are underwritten by AmFirst Insurance Company

Fraud Notice

Arkansas 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.

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.

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 fines and confinement in prison.

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.

Oklahoma 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.

Tennessee 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.

Virginia Any person who, with the 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 may have violated the state law.

General Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application.

Employee Signature

Date

SERFF Tracking Number: LWEL-126388249 State: Arkansas
 Filing Company: AmFirst Insurance Company State Tracking Number: 44200
 Company Tracking Number: AF-GTLP (11/09)
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life Insurance Plan
 Project Name/Number: Group Term Life Insurance Plan/AF-GTLP (11/09)

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attachments: AR-readability-cert-GTL.pdf AR-Notice.pdf Arkansas-Rule&Regulation19.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: See Form Schedule Tab for Application. Comments:</p>		
<p>Satisfied - Item: Statement of Variability Comments: Attachment: AmFirstGroupLifeStmnt of Variables.pdf</p>		
<p>Satisfied - Item: Third Party Authorization Letter Comments: Attachment: Lewis&Ellis Authorization letter 8-6-09.pdf</p>		

November 30, 2009

State of Arkansas

Re: Readability Certification for Policy Forms
AmFirst Insurance Company

To Whom It May Concern:

The following forms have been tested for readability and meet the minimum reading ease score as required by the state of Arkansas.

Form Number	Flesch Score
AF-GTLP (11/09), et al	51.2



Rebecca Ewing, FLMI, HIA ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc. – Actuaries & Consultants

**IMPORTANT INFORMATION FOR
ARKANSAS POLICYOWNERS**

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

AmFirst Insurance Company
P.O. Box 14067
Jackson, Mississippi 39236

Telephone: 1-800-252-3439

Agent _____
Address _____

Telephone _____

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494
1-501-371-2640

E-Mail: Insurance@mail.state.ar.us
Web Site: www.state.ar.us/insurance

AF-NOTICE-AR

Arkansas – Rule and Regulation 19 Certification of Compliance

Please accept our assurances that this submission meets the provisions of Regulation 19 along with all other applicable requirements of the Arkansas Insurance Department.

AmFirst Insurance Company

A handwritten signature in black ink, appearing to read "David White". The signature is written in a cursive style with a large initial "D".

David White, President

Date: 11/22/09

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

Group Term Life Insurance Policy Form AF-GTLP (11/09)

Page 1

1. Variable area following "Policyholder" will be completed with the name of the policyholder.
2. Variable area following "Policy Number" will be completed with the number assigned by AmFirst.
3. Variable area following "Policy Effective Date" will be completed with the date the policy goes into effect.
4. The left signature box will be completed with the Policyholder's name and will be manually signed and dated an appropriate official of the policyholder.
5. The right signature box will be completed by an appropriate officer of AmFirst.

Page 2

1. Under "Payment of Premiums" the appropriate AmFirst payment address will be completed at the time of issue.

Page 3

1. Under "Grace Period," the sentences "AmFirst will waive the Policyholder's premium payment on a monthly basis, beginning the first day of the month after the month a Covered Person becomes Totally Disabled (as such term is defined in the Certificate of Coverage) with respect to such Covered Person only. AmFirst will refund any premium paid under the Policy after that day. AmFirst will not refund premiums for any period more than {1-3 months} before the date proof of the Covered Person's Total Disability is furnished." Will be included if waiver of premium for total disability is elected by the policyholder. Otherwise, these sentences will be omitted.

In the third sentence above, AmFirst will refund premium s for 1, 2 or 3 months depending upon the election of the policyholder.

2. Under "Premium Rate Change"
 - a. a change in the number of insureds will range from 5% to 20% depending upon the election of policyholder.
 - b. The notification period prior to a change in rates will range from 10 to 90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.
3. Under "Termination of the Policy by Policyholder"
 - a. the prior notification period during which the policyholder must notify its employees/participants will range from 10 to 90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.
 - b. The phrase "including the right to convert coverage upon termination" will be included or excluded.

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

- c. The number of days AmFirst must give prior written notice of termination will range from 30 to 90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.

Pages 3-4

1. Under "Termination of the Policy by AmFirst," the bracketed conditions c, d, g and h will be included or excluded depending upon the circumstances of the case.

Page 5

1. Under "Misstatement of Age," the phrase "or such Dependent's" will be included if dependents are to be covered. Otherwise, this phrase will be omitted.

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

Group Term Life Certificate of Coverage Form AF-GTLC (11/09)

Page 1

1. Variable area following “Policyholder” will be completed with the name of the policyholder.
4. Variable area following “Policy Effective Date” will be completed with the date the policy goes into effect.
5. Variable area following “Policy Number” will be completed with the number assigned by the AmFirst.
4. Variable areas following “Covered Person” will be completed with the name of the covered employee/participant to whom the certificate is issued.
5. Variable area following “Certificate Number” will be completed with the number assigned by AmFirst.
6. Variable areas following “Certificate Effective Date” will be completed with the date the certificate goes into effect.
7. Under “Read the Certificate Carefully,” the appropriate “800” contact number(s) for AmFirst will be inserted.

Page 2

1. Under the “Table of Contents,” the bracketed material will be included or omitted depending upon the plan negotiated between the policyholder and AmFirst.
2. At time of issue, the proper page numbers will also be shown.

Page 3

1. Under “Schedule of Benefits for Covered Person”
 - a. “Cost of Insurance”
 - i. The covered person “is” required to contribute to the cost of his insurance if the plan is a contributory plan.
 - ii. The covered person “is not” required to contribute to the cost of his insurance if the plan is a non-contributory plan.
 - b. The “Basic Life Insurance Benefit” will range from \$10,000 to \$400,000 OR from 1 to 10 times the covered person’s salary depending upon the selection of the policyholder.
 - c. The “Basic Life Insurance Benefit Reduction” will go into effect at the covered person’s attained age of 60, 65, 70, 75 or 80 at the election of the policyholder, and will continue to decrease in accordance with the following schedule showing a reduction range of from “0%” to “100%” at the specified attained age.

Reductions will take effect on either the specified “date” or on the “first day of the calendar month in which the covered person attains the specified age.

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

- d. The “Accelerated Death Benefit” will be limited to 25%, 50% or 75% of the basic life insurance amount less an amount ranging from \$0 to \$25,000 dollars.

The maximum benefit will be limited to an amount ranging from \$0 to \$400,000.

The covered person must have at least from \$10,000 to \$50,000 in basic life insurance in force to qualify for this benefit.

- e. The maximum “Supplemental Life Insurance Benefit” will range from \$0 to \$2,000,000.

Page 3-4

1. The “Supplemental Life Insurance Benefit Reduction” will go into effect at the covered person’s attained age of 60, 65, 70, 75 or 80 at the election of the policyholder, and will continue to decrease in accordance with the following schedule showing a reduction range of from “0%” to “100%” at the specified attained age.

Pages 5

1. The “Schedule of Benefits for Dependent {Spouse} {and} {Child}” will be included if dependents coverage is elected by the policyholder.
2. If covered, a Spouse’s Basic Life Insurance Benefit will range from \$5,000 to \$500,000.
3. There will be two options available to the policyholder.

Option 1 is to provide a benefit from \$100 to \$2,000 for dependent children ages 0 to 6 months AND a benefit ranging from \$2,000 to \$100,000; OR

Option 2 is to provide a benefit for all dependent children regardless of age a benefit ranging from \$2,000 to \$100,000.

In no event will any spouse or dependent child benefit exceed 25%, 50% or 75% of the covered person’s benefit amount.

4. The “Basic Life Insurance Benefit Reduction” will go into effect at the covered spouse’s attained age of 60, 65, 70, 75 or 80 at the election of the policyholder, and will continue to decrease in accordance with the following schedule showing a reduction range of from “0%” to “100%” at the specified attained age.

Reductions will take effect on either the specified “date” or on the “first day of the calendar month in which the dependent spouse attains the specified age.

5. The “Accelerated Dependent Spouse Death Benefit” will be limited to 25%, 50% or 75% of the basic life insurance amount less an amount ranging from \$0 to \$25,000 dollars.

The maximum benefit will be limited to an amount ranging from \$0 to \$400,000.

The covered spouse must have at least from \$10,000 to \$50,000 in basic life insurance in force to qualify for this benefit.

6. The maximum “Supplemental Life Insurance Benefit for Dependent Spouse” will range from \$0 to \$2,000,000.

AmFirst Insurance Company
Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms

Pages 5-6

1. The “Supplemental Life Insurance Benefit Reduction” for a covered spouse will go into effect at the covered spouse’s attained age of 60, 65, 70, 75 or 80 at the election of the policyholder, and will continue to decrease in accordance with the following schedule showing a reduction range of from “0%” to “100%” at the specified attained age.

Reductions will take effect on either the specified “date” or on the “first day of the calendar month in which the dependent spouse attains the specified age.

Page 7-8

1. In the definition of “Active Work or Actively at Work,” and be considered active if he/she works a minimum number of hours per week ranging from 10 to 40 hours per week at the election of the policyholder.
2. The definition of “Domestic Partner” will be included if the policyholder.

The policyholder may also elect one or more of the following bracketed conditions to qualify a domestic partner.

Page 8

1. An “Eligible Employee” may be defined as an employee “who has been Actively at Work for a continuous period of {1-6} month{s}” **OR** as an employee “who has been Actively at Work for the continuous period as specified by Policyholder.”

The exception for an employee on active duty allows an exception for short-duration duty ranging from 5 to 31 days or less for training in the Reserves or National Guard at the election of the policyholder.

2. The definition of “Injury” may be modified to comply with state requirements. Otherwise, the definition as shown will be used.

Page 10

1. In the “Incontestability” provision, the bracketed sentence may be included or deleted at the AmFirst’s option.

Page 11

1. In the “Misstatement of Age” provision, the bracketed phrase “or a Dependent’s” will be included if dependents coverage is elected. Otherwise, this phrase will be omitted.
2. In the “Termination of the Policy by Policyholder” provision
 - a. the prior notification period during which the policyholder must notify its employees/participants will range from 10 to 90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.
 - b. The phrase “including the right to convert coverage upon termination” will be included or excluded.
 - d. The number of days AmFirst must give prior written notice of termination will range from 30 to

AmFirst Insurance Company

Statement of Variables for Group Term Life Insurance Policy and Certificate Forms

90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.

3. In the "Termination of the Policy by AmFirst" provision, the bracketed conditions e, f, g and h will be included or excluded depending upon the circumstances of the case

Page 12

1. The number of days AmFirst must give prior written notice of termination will range from 30 to 90 days depending upon the election the policyholder and state law. In all cases, state law will prevail unless the required number of days is less than the number of days elected by the policyholder.

Page 13

1. In the "Covered Person's Eligibility" provision, "an Eligible Employee is automatically enrolled in and becomes a Covered Person under the Policy" in a non-contributory plan or "an Eligible Employee is eligible for insurance under the Policy" if contributory plan.

Pages 13-14

1. In the "Enrolling in or Changing Insurance under the Policy" provision, option "A" will be used with non-contributory plans; option "B" will be used with contributory plans; option "C" will be used if the plan is non-contributory and there is dependents coverage; and, option "D" will be used if the plan is contributory and there is dependent coverage.

Page 14

1. The "Evidence of Insurability for Supplemental Life Insurance" may be included or omitted at the option of the AmFirst.
2. The "Rehired Employee" provision may be included or omitted at the option of the policyholder.
3. In the "Effective Date of Covered Person Insurance" provision, the first bracketed paragraph will be used if the plan is non-contributory. The second bracketed paragraph will be used if the plan is contributory.

Pages 14-15

4. In the "Nonpayment of Benefits" provision, part "b" will be used when Supplemental Life benefits are elected.

Page 15

1. In the "Termination of Covered Person Insurance" provision, part "g" will be used if the plan is contributory; otherwise, "g" will be omitted.

Page 16

1. The "Continuity of Insurance" provision will be included if the policy replaces an existing group coverage.
2. The first three paragraphs of the "When the Covered Person Retires" provision will be included if the policyholder elects to continue coverage for his retired employees.

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

Page 18

1. The entire “Dependent Eligibility, Effective Date and Termination Provisions” will be included if dependents coverage is elected by the policyholder.

Page 20

1. In the “Notice of Claim” provision, the proper address will be inserted.

The covered person’s beneficiary or representative will have from 15 to 60 days, at the election of the policyholder, to send written notice of claim, or as soon thereafter as reasonably possible.

2. In the “Proof of Claim” provision, written proof must be filed within 60 to 180 days at the election of policyholder, or no later than 1 year if legally incapable of submitting proof.

Page 21

1. Under “Total Disability for Covered Person”
 - a. The phrase “and supplemental” will be included if supplemental life insurance benefits are included.
 - b. The insured must become totally disabled before a specified age ranging from 55 to 65 at the election of the policyholder.
 - c. the insured must remain totally disable for a period of time ranging from 6 to 12 months at the election of the policyholder.
2. In the “Amount of Life Insurance under the Total Disability Benefit” provision, the phrase “and supplemental” will be included if supplemental life insurance benefits are provided.
3. In the “Proof of Total Disability” provision, proof of total disability must be submitted with 6 to 9 months at the policyholder’s election. If AmFirst requests additional proof, such proof must be submitted, at the policyholder’s election, within 30 to 90 days.
4. The policyholder may also elect a “Waiver of Premium” provision for total disability. If elected, this provision will be included; otherwise, it will be omitted.

Page 22

1. The policyholder may elect “Evidence of Insurability for Supplemental Life Insurance under the Total Disability Benefit.” If elected, this provision will be included; otherwise, it will be omitted.
2. In the “Termination of the Total Disability Benefit” provision, the phrase “and supplemental” will be included if supplemental life insurance benefit is elected; otherwise, this phrase will be omitted.

Page 23

1. The phrase “and Dependent Spouse” in the first paragraph will be included if dependents coverage is elected; otherwise, this phrase will be omitted.
2. The phrases “or Dependent Spouse” and “or Dependent Spouse’s” in the second paragraph will be included if dependents coverage is elected; otherwise, this phrase will be omitted.

AmFirst Insurance Company

Statement of Variables for Group Term Life Insurance Policy and Certificate Forms

3. The variable life expectancy will range from 6 to 12 months depending upon the election of the policyholder. This time period may be longer than 12 months if required by state law; in which case, the longer state-required time period will be used.
4. The phrase “or Dependent Spouse” as used in the “Proof of Terminal Illness” provision will be included if dependents coverage is elected; otherwise, this phrase will be omitted.
5. The variable life expectancy, as used in the “Proof of Terminal Illness” provision, will range from 6 to 12 months depending upon the election of the policyholder. This time period may be longer than 12 months if required by state law; in which case, the longer state-required time period will be used.
6. The phrase “or Dependent Spouse” as used in the “Physical Examination and Autopsy” provision will be included if dependents coverage is elected; otherwise, this phrase will be omitted.
7. The two “Limitations” are variable and subject to negotiation with the policyholder and may be included or omitted.

Page 24

1. The entire “Life Insurance Benefit for Dependents” is optional and will be included if dependents coverage is elected by the policyholder; otherwise, this entire Benefit will be omitted.

Page 26

1. The phrase “the Dependent,” wherever used in this section, will be included if dependents coverage is elected by the policyholder; otherwise, it will be omitted.
2. The minimum and maximum time frames shown throughout this section are subject to negotiation with the policyholder

Page 27

1. The phrase “the Dependent,” wherever used in this section, will be included if dependents coverage is elected by the policyholder; otherwise, it will be omitted.
2. The minimum and maximum time frames shown throughout are subject to negotiation with the policyholder
3. Either the first or the second “Appeals” paragraphs will be used depending upon the circumstances of the coverage.

Page 28

1. The phrases “Dependent” and “the Dependent,” wherever used in this section, will be included if dependents coverage is elected by the policyholder; otherwise, these phrases will be omitted.
2. In the “Exhaustion of Process” provision, the proper agency name will be inserted.
3. In the “ERISA Rights” provision, the phrases “Dependent” and “the Dependent” will be included if dependents coverage is elected by the policyholder; otherwise, these phrases will be omitted.

AmFirst Insurance Company

Statement of Variables for Group Term Life Insurance Policy and Certificate Forms

Pages 29-31

1. The entire "Portability Privilege" section is optional and will be included if elected by the policyholder.
2. References to "Dependents" will be included if dependents coverage has been elected by the policyholder; otherwise, these references will be omitted.
3. Minimum and maximum age and benefits ranges are shown throughout the text. The actual number will be negotiated with the policyholder.

Pages 32-33

1. "Covered Person Conversion" will be included in every state where conversion is required. It will be an option only in those states that do not require conversion.
2. Minimum and maximum age, time and benefits ranges are shown throughout the text. The actual number will be negotiated with the policyholder within the framework of the given ranges.

Page 34

1. "Dependent Conversion" will be included in every state where dependents conversion is required. It will be an option only in those states that do not require dependent conversion.
2. Minimum and maximum age ranges are shown throughout the text. The actual number will be negotiated with the policyholder within the framework of the given ranges.

Page 35-39

1. The "Accidental Death and Dismemberment ("AD&D") Benefit" is optional and will be included if elected by the policyholder.
2. References to "Dependents" will be included if dependents coverage has been elected by the policyholder; otherwise, these references will be omitted.
3. Minimum and maximum age, time and benefit ranges are shown throughout this Benefit. The actual number will be negotiated with the policyholder within the framework of the given ranges.

Page 40-41

1. The "Accidental Death and Dismemberment ("AD&D") Benefit" is optional and will be included if elected by the policyholder.
2. References to "Dependents" will be included if dependents coverage has been elected by the policyholder; otherwise, these references will be omitted.
3. Minimum and maximum age, time and benefit ranges are shown throughout this Benefit. The actual number will be negotiated with the policyholder within the framework of the given ranges.

AmFirst Insurance Company

**Statement of Variables for
Group Term Life Insurance Policy and Certificate Forms**

Page 42

1. The “Repatriation Benefit for Covered Person {and AD&D Dependent}” is optional and will be included if elected by the policyholder.
2. References to “Dependents” will be included if dependents coverage has been elected by the policyholder; otherwise, these references will be omitted.
3. Minimum and maximum distance, time and benefit ranges are shown throughout this Benefit. The actual number will be negotiated with the policyholder within the framework of the given ranges.



AmFirst
Insurance Company

August 6, 2009

Lewis & Ellis, Inc.
2929 North central Expressway, Suite 200
P.O. Box 85187
Richardson, Texas 75085

To Whom It May Concern:

This letter or a copy thereof, confirms the authority of Lewis & Ellis, Inc. to submit on behalf of AmFirst Insurance Company (the Company), the required forms and rates for any insurance products to the insurance departments of those jurisdictions in which the Company is licensed, and to represent the Company in the negotiation of the approval of said forms and rates, including the provision of necessary assurances and commitments regarding specific conditions of the forms to secure said approvals.

This authorization shall be valid until such time as it is revoked by the Company.

Sincerely,

Richard L. Eaton
Chief Financial Officer
AmFirst Insurance Company