

SERFF Tracking Number: NWLC-126115288 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 42128
Company Tracking Number: NSHGTL 2000
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: NSHGTL 2000 et al
Project Name/Number: /

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: NSHGTL 2000 et al

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: NWLC-126115288 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 42128

Co Tr Num: NSHGTL 2000

Author: Susan Coulter

Date Submitted: 04/15/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 04/21/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/21/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 04/21/2009

Created By: Susan Coulter

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Susan Coulter

Filing Description:

On behalf of Nationwide Life Insurance Company, Coulter and Associates is hereby submitting the referenced forms for your review and approval for use.

This is a general use filing for Nationwide's group term life product. This product will be marketed only to qualified large employer groups in your state.

These forms are new and do not replace any forms previously approved by your department.

The forms listed provide:

- basic renewable term life benefits
- optional supplemental term life benefits

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- optional accidental death and dismemberment benefits
- optional accelerated death benefits

Variable text is bracketed throughout the document. Such text will either be included or excluded. Bracketed time frames will allow for variations shown and will comply with your state minimum requirements.

The forms have been filed concurrently in Nationwide's domicile state of Ohio.

We trust you will find this submission complete and these forms to be acceptable for use in your state. Please do not hesitate to contact me should you have any questions or concerns.

Company and Contact

Filing Contact Information

Susan Coulter, susan@coulter-and-associates.com
 379 Princeton-Hightstown Road 609-443-7940 [Phone]
 Suite 15
 Cranbury, NJ 08512

Filing Company Information

Nationwide Life Insurance Company CoCode: 66869 State of Domicile: Ohio
 5525 Parkcenter Circle Group Code: 140 Company Type:
 Dublin, OH 43017 Group Name: State ID Number:
 (800) 525-8669 ext. 43508[Phone] FEIN Number: 31-4156830

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	04/15/2009	27192217

<i>SERFF Tracking Number:</i>	<i>NWLC-126115288</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Nationwide Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42128</i>
<i>Company Tracking Number:</i>	<i>NSHGTL 2000</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.500 Other</i>
<i>Product Name:</i>	<i>NSHGTL 2000 et al</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/21/2009	04/21/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Wellness Endorsement	Susan Coulter	04/20/2009	04/20/2009

SERFF Tracking Number: *NWLC-126115288* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *42128*
Company Tracking Number: *NSHGTL 2000*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.500 Other*
Product Name: *NSHGTL 2000 et al*
Project Name/Number: /

Disposition

Disposition Date: 04/21/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NWLC-126115288 State: Arkansas
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 Product Name: NSHGTL 2000 et al
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statment of Variability		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Cover letter		Yes
Form	Policy		Yes
Form	Certificate of Coverage		Yes
Form	Schedule of Benefits		Yes
Form	Policyholder Application		Yes
Form	Evidence of Insurability		Yes
Form	Wellness Endorsement		Yes

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Amendment Letter

Submitted Date: 04/20/2009

Comments:

At the time we originally submitted this filing, we neglected to include an endorsement - NSHGTL 2700 - Wellness. The purpose of this endorsement is to inform the policyholder that, from time to time, we may offer the Insureds access to certain health and/or wellness programs and services . It will be attached to each policy at the time of issue. As stated in the endorsement, there is no additional charge or required premium for programs or services offered pursuant to this endorsement.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NSHGTL 2700 - Wellness	Policy/Contract/Fraternal Certificate: t Amendment, Insert Page, Endorsement or Rider	Wellness	Initial					NH 2700 - Wellness Rider.pdf

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Form Schedule

Lead Form Number: NSHGTL 2000

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	NSHGTL 2000	Policy/Cont ract/Fraternal Certificate	Policy	Initial		67.300	NSHGTL 2000 Group Policy.pdf
	NSHGTL 2500	Certificate	Certificate of Coverage	Initial		62.800	NSHGTL 2500 Certificate of Coverage.pdf
	NSHGTL 2500- SCHED	Schedule Pages	Schedule of Benefits	Initial		65.900	NSHGTL 2500- SCHED.pdf
	NSHEMP 2300	Application/ Enrollment Form	Policyholder Application	Initial			NSHEMP 2300 Group App.pdf
	NSHGTL 2800-1	Application/ Enrollment Form	Evidence of Insurability	Initial			NSHGTL 2800-1 Eol Form.pdf
	NSHGTL 2700 - Wellness	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Wellness Endorsement	Initial			NH 2700 - Wellness Rider.pdf

GENERAL PROVISIONS

Agency

The Policyholder and any administrator appointed by the Policyholder shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Entire Contract

The entire contract consists of:

1. this Policy;
2. the Certificate;
3. any Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy or Certificate;
4. the Application of the Policyholder; and
5. [the Enrollment Form of the Certificate Holder.]

A copy of the Policyholder's Application is attached to this Policy on the date it is signed. All statements made in the Application and Enrollment Form, in the absence of fraud, are representations and not warranties. No statement made by an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured Person.

Individual Certificate

We will make a certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which the Insured Person is entitled and to whom the benefits are payable.

Conformity With State Laws

The insurance laws of some states require that certain Policy provisions comply with the law of the state for all permanent residents of the state. Any Policy provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements. However, any such provision is modified only for an Insured Person who is a permanent resident of the state at the time Covered Expenses are actually incurred as defined herein.

Misstatements

If any relevant fact as to a Covered Person to whom this insurance relates is found to have been misstated, the true facts will be used to determine whether his or her insurance is in force under the Policy and at what coverage level. If the error has an effect on the Premium, an adjustment of the Premium due will be made.

Non-Participating

This Policy is non-participating. This means that it does not share in Our surplus earnings.

Assignment

No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us.

Incontestability

[Except for material fraudulent misstatements,] this Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

Clerical Error

Any clerical error by Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

Changes In Policy

The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our Executive Vice President or Our Corporate Secretary. Any changes will be made without the consent of, or notice to, any Insured Person. No agent has authority to contract directly with Us for this Policy or to change, alter or amend any of its terms or provisions in any way.

Policyholder Required Information

Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

Incorporation Provision

The provisions of the attached Certificate of Insurance, any Rider(s), and any Endorsement(s), including any Rider or Endorsement added after the Effective Date, are made a part of this Policy. The Certificate(s) and Rider(s) attached to this Policy will control each Covered Person's coverage eligibility, effective date, termination date, benefits, limitations and exclusions.

New Entrants

New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

PREMIUM PROVISIONS**[Payment of Premiums**

The Premiums due under this Policy are payable in advance directly to Us. The first Premium is due on the Effective Date of this Policy. Premiums after the first payment are due on the Premium Due Date as defined by Us. The payment of any Premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the Grace Period provision. All payments made to Us will be made in United States dollars.]

[Premium Calculation

The total Premium owed to Us under this Policy is obtained by multiplying the number of Covered Persons [in each tier category] by the applicable Premium rates in effect for all Covered Persons covered under this Policy and then summing the results.]

Premium Adjustments

When additional or increased insurance begins or ends and the change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly).

Changes in Premium Rates

We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the Premium rates more than once in any [1-60] month period. We will notify the Policyholder in writing at least [30-365] days in advance of any increase.

[Premium Rate Guarantees

Any Premium rate guarantees are subject to the following provisions:

1. The benefits outlined in the Certificate as well as the eligibility remain unchanged;
2. There are no additions or deletions of subsidiaries or affiliates;
3. The census or geographic distribution does not change by more than [1%-100%, 1% increments];
4. [The employer contribution, if applicable, to the Premium is not reduced.]

[Policyholder Grace Period - Policyholder

A Grace Period of [30-365] days (without interest charge) is granted for the payment of any Premium Due Date after the first payment. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the Premium is not paid by the end of the Grace Period all insurance under this Policy will end on the last day of the Grace Period, and the Policyholder will owe Us all Premiums then due and unpaid including the Premium for the Grace Period.

[If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the [last day of the Grace Period] [date We receive the written notice or the date specified, if later] Agent. [The Policyholder will owe Us the pro-rata Premium for the time the insurance was in effect during the Grace Period.]]

TERMINATION OF INSURANCE

The Policy will continue for as long as premiums are paid or until it is terminated or cancelled. Notice to cancel or terminate the Policy may come from either the Policyholder or from Us. The Policyholder may cancel any or all of the insurance by giving Us written notice. It will terminate on the later of:

1. the date requested in the cancellation notice; or
2. the [date][last day of the month following the date] We receive the notice.

We may terminate insurance as of a premium due date with a [30-365] day advance notice in writing to the Policyholder. However, prior to the first Policy anniversary, We may only do this:

1. if the Policyholder does not perform its duties under the Policy to Our satisfaction; or
2. [less than [1%-100%, 1% increments] of those eligible are enrolled for insurance].

In either event, Premium is due and payable through the date on which coverage under the Policy terminates. If the premium is not paid, the Policy will terminate as of the last day for which premium was paid.

Insurance will end as provided above without the consent of, or notice to, any Insured Person, unless otherwise required by state law.



On Your Side®

Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio

CERTIFICATE OF COVERAGE

[GROUP] [BASIC] [VOLUNTARY] [TERM] [LIFE PLAN] [WITH] [ACCIDENTAL DEATH [AND DISMEMBERMENT BENEFITS]]

INSURING AGREEMENT

The Nationwide Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder.

The Benefits of the Policy are described in this Certificate.

Final interpretation is governed by the Policy. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

The Benefits and provisions of the Policy are described in this Certificate. Please read Your Certificate carefully. Keep it in a safe place.

[Fraud: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to criminal and civil penalties.]

Signed for Nationwide Life Insurance Company

[
Secretary

]

[

President

]

{The following is included if the Policyholder elects an Accelerated Death Benefit.}

[IMPORTANT NOTICE REGARDING ACCELERATED DEATH BENEFITS

This Certificate contains an Accelerated Death Benefit provision within the Life Insurance section. Benefits are payable as shown on the Schedule of Benefits. Please refer to the Accelerated Death Benefit provision of this Certificate for a complete Benefit description.

This Accelerated Death Benefit is **NOT** a long-term care policy or a nursing home insurance policy. You may use the Accelerated Death Benefit for any purpose. The Accelerated Death Benefit may be taxable. As with all tax matters, You should consult a personal tax advisor to determine the tax consequences prior to making an election for this Benefit.

[BASIC] LIFE INSURANCE [AND VOLUNTARY LIFE INSURANCE BENEFITS, IF APPLICABLE,] WILL BE REDUCED IF AN ACCELERATED DEATH BENEFIT IS PAID.

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS, BUT NOT LIMITED TO, MEDICAID. Because the Accelerated Death Benefit is a part of this Certificate, You may be required to receive and spend all of the available funds from the Certificate prior to becoming eligible for public assistance programs.]

The Policy under which the Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person who claims rights or Benefits under the Policy.]

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GENERAL DEFINITIONS

[Accident or Accidental or Accidental Injury: A specific unforeseen event, that is sudden, unexpected, and unintended, over which a Covered Person has no control and which happens while the Covered Person is covered under this Policy and which directly, and from no other cause, results in an Injury.]

[Accredited: The school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S., Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC.]

[Actively at Work: You are performing the normal duties of Your regular occupation and working Your normal hours. [You must be working at least [1-40] hours per week for the Policyholder on a [permanent] [Full-Time][Part-Time] basis and must be paid regular earnings.]

Your work site must be:

1. at the Policyholder's usual place of business; or
2. at a location to which the Policyholder's business requires You to travel.

You are not considered Actively at Work when You are off work or lose time due to illness, injury, leave of absence, strike or lay-off. [Paid days off will count as Actively at Work if You were fully capable of performing the normal duties of Your regular occupation during the paid days off, provided that You were Actively at Work on the last working day prior to the paid days off.]]

[Actively at Work: Reporting to the Policyholder's regular place of employment and carrying out the regular duties of Your occupation for the number of hours required to meet the definition of Eligible Person. [You will also be considered Actively at Work on each day of other paid time off provided You were Actively at Work on the date preceding the date of such paid time off.]

[Additional Benefit: An addendum to the Policy which increases or limits Coverage for a specified set of conditions. The provisions, limitations, and exclusions in the entire Policy will apply unless specifically stated otherwise in the Additional Benefit.]

[Aircraft, Chartered: An aircraft the Policyholder does not own but hires for an occasional specific trip. The time the Policyholder has it may not exceed [2-30] consecutive days or more than [1-30] days in any one [1-36] month period. One or more aircraft hired on a regular or frequent basis are not considered chartered.]

[Annual Earnings: Your basic gross [annual] rate of compensation. It does not include [overtime], [bonuses], [profit sharing] [or] [other forms of extra compensation]. Commission earnings shall be Your average commissions as of the most recent [January 1] for Your prior [one, two, three] [year, years] in the employ of the Policyholder. But if You have not been employed for [one, two, three] [year, years] as of the most recent [January 1], Your commission earnings shall be Your average commissions earned during the period You have been employed by the Policyholder.

[For part-time employees, the rate of compensation will be based on [a [1-40] hour work week].]

[Your amount of insurance will be calculated based on the lesser of Your Annual Earnings as calculated above or the premium amount actually received by Us.]

[Annual Earnings: Your annual gross base earnings in effect from the Policyholder. [It does not include [bonuses], [overtime pay], [and extra compensation] [other than commissions]]. Commission earnings shall be Your average commissions as of the most recent [January 1] for Your prior [three years] in the employ of the Policyholder. But if You have not been employed for [one, two, three] [year, years] as of the most recent [January 1], Your commission earnings shall be Your average commissions earned during the period You have been employed by the Policyholder.

If Your income includes [commissions], [bonuses], [dividends], [overtime], [profit sharing] Your Annual Earnings will be calculated as follows:

1. If You have been employed by the Policyholder for at least [one, two, three] calendar [year, years], Your average annual gross earnings as an employee during the immediately preceding [[two, three] [calendar year] [calendar years] as set forth on Your [W-2 Withholding Statement][IRS Form 1065], [Schedule K-1][quarterly Wage and Tax Register, annualized].
2. If You have been employed by the Policyholder for less than [[one, two, three] calendar [year, years], the amount that is estimated by the Policyholder. The estimate must reflect a reasonable expectation of the income to be earned. We will verify the estimate with the Policyholder at the time a Claim is submitted to Us. Benefits will be based on the lesser of (a) Your actual earnings or (b) the estimated level of earnings.

Annual Earnings will be calculated based on the lesser of:

1. the premium amount actually received by Us; or
2. Your annual gross base earnings as outlined above.]

[Annual Earnings: Your [basic gross rate of compensation [from the Policyholder]] [Your [annual] [wage] [or] [salary] from the Policyholder]. It does not include [overtime], [bonuses], [profit sharing], [commissions] [or other forms of extra compensation].] [Commission earnings shall be Your average commissions as of the most recent [January 1] for Your prior [three years] in the employ of the Policyholder. But if You have not been employed for [one, two, three] [year, years] as of the most recent [January 1], Your commission earnings shall be Your average commissions earned during the period You have been employed by the Policyholder.]

[Your amount of insurance will be calculated based on the lesser of Your Annual Earnings as calculated above or the premium amount actually received by Us.]
[Annual Earnings will be determined according to the Policyholder's records.]]

[Annual Earnings: Your prior [year's] [W-2] earnings. If You are a first-year employee of the Policyholder, insurance will be calculated based on annualized current earnings, as determined according to the Policyholder's records.]

[Annual Earnings: Your [annual] [wage] [or] [salary] from the Policyholder, [including [commissions,] [bonuses,] [overtime pay,] [and] [profit sharing] averaged over the prior [[1-36] months]]. [[Commissions,][bonuses,][overtime pay,][profit sharing] [and any other compensation] will be excluded when determining this [wage] [or] [salary].] Annual Earnings will be determined according to the Policyholder's records.] [Commission earnings shall be Your average commissions as of the most recent [January 1] for Your prior [one, two, three] [year, years] in the employ of the Policyholder. But if You have not been employed for [one, two, three] [year, years] as of the most recent [January 1], Your commission earnings shall be Your average commissions earned during the period You have been employed by the Policyholder.]]

[Beneficiary: The one who will receive Benefits payable upon a Covered Person's death. You may designate or change the Beneficiary at any time by filing written notice on a form We provide and sending it back to the [Policyholder] [Our Agent or Us.]

Benefit: The dollar amount payable by Us to a Claimant or Beneficiary under the Policy.

[Calendar Year: For the first year is the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, it is the period of time that begins on January 1st and ends December 31st. [The Effective Date is shown in Your Schedule of Benefits.]]

Certificate: This document which provides a description of the Coverage available under the Policy.

[Child or Children: See definition of Eligible Dependent.]

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a claim for Benefits under the Policy, as a Covered Person or as the Beneficiary of a Covered Person.

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

[Contributory: You pay all or a portion of the premium for the Coverage.]

Coverage: The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

Covered Person: You and Your Eligible Dependents whom You have enrolled for insurance and paid any Premium due under the Policy.

[Covered Spouse: Your eligible Spouse who is insured under the Policy.]

[Dependent or Covered Dependent: Your Eligible Dependent who is insured under the Policy.]

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

1. [For at least [1-36] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and]
2. [Your Domestic Partner is at least 18 years of age; and]
3. [You and Your Domestic Partner are not married or related by blood; and]
4. [You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and]
5. [You and Your Domestic Partner have filed a Domestic Partner affidavit [with Us]; and]
6. [You and Your Domestic Partner are not legally married to anyone else.]]

Effective Date: The date on which insurance Coverage begins under the Policy.

Eligible Class: Is a group of people who are eligible for Coverage under the Policy. [See the Schedule of Benefits for a list of Eligible Classes.] Each person of the Eligible Class will qualify for insurance on the date he or she completes the required Eligibility Waiting Period, if any.

[Eligible Dependent: Includes:

1. Your Spouse (if not legally separated or divorced from You);
2. Your unwed Child from the moment of birth, until the Child attains Age [19-40]; and
3. [Your unwed Child who is a student may be covered until Age [22-40] provided such Child is a Full-Time Student and more than 50% dependent on You for support and maintenance and proof of the Child's enrollment as a Full-Time Student is submitted to Us.]

Children include natural children, stepchildren, adopted children, [grandchildren] children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a child where an Eligible Person has the assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation.

[The term Eligible Dependent does not include any person who:

1. [is in full-time active duty in the armed forces of any country or international authority; or]
2. [lives outside of the United States [or Canada][Mexico]]; or
3. [is an Insured Person under the Policy.]]

Eligible Person: A person who belongs to an Eligible Class [as described in the Schedule of Benefits].

[Eligibility Waiting Period: The continuous length of time You must serve in an Eligible Class to reach Your eligibility date and begin Your Coverage [and Your Eligible Dependent Coverage.] [The Eligibility Waiting Period is shown in the Schedule of Benefits.]]

[Enrollment Form: The document completed by You in electing Coverage under the Policyholder's Policy.]

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

[Family Plan: You and Your Eligible Dependents are covered under the Policy]

[Full-Time: A regular workweek as defined [by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.]

[Full-Time Student: A student who is enrolled in an Accredited educational institution or licensed trade school and considered full time according to the institution or school that he or she is attending.]

[Guaranteed Issue Amount: An amount of insurance for which We do not require Proof of Insurability.]

Group: A Policyholder or entity who has entered into a contract with Us to provide Coverage under the Policy.

Illness: Includes:

1. an illness that impairs [a Covered Person's] normal functioning of mind or body; and

2. the pregnancy, childbirth and related medical conditions of [a Covered Person].

[Independent Medical Exam: An examination by a Provider of the appropriate specialty for a Covered Person's] condition at Our expense. Such examination, scheduled by Us, may be used for the purpose of determining eligibility for insurance or Benefits, including eligibility under the Additional Benefits, if any, associated with the Policy.]

Injury: Bodily harm which is the direct result of an Accident and not related to any other cause.

Insured Person: A person who is an Eligible Person, who has qualified for insurance by completing any Eligibility Waiting Period, paid any premium due, and for whom insurance under the Policy has become effective.

[Leave of Absence: An arrangement where You and the Policyholder agree that You will not be Actively at Work for a specific period of time and You are expected to be Actively at Work at the end of that period. Refer to When Your Insurance Ends to determine how long Your Coverage can be continued during a Leave of Absence.]

[Medically Necessary: Services or supplies that are:

1. appropriate and necessary for the symptoms, diagnosis, or treatment of the Injury;
2. provided for the diagnosis or direct care and treatment of the Injury;
3. consistent with generally accepted professional standards of care within the organized medical community;
4. not primarily for the convenience of the Covered Person or Covered Person's Provider, or another health care provider; and
5. the most appropriate supply or level or service which can safely and effectively be provided.]

[Part-Time: A schedule of work defined as part-time by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.]

Placement for Adoption; Placed for Adoption: A Child is placed in Your physical custody for the purpose of adoption.

Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year or Policy Year.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations, and the exclusions regarding Coverage.

Policy Anniversary: The month and day as shown on the Policy as the Policy Anniversary.

[Policy Year: For the first year is the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary. [The Policy Year is shown in Your Schedule of Benefits.]]

Policyholder: The organization [named in the Schedule of Benefits] who has contracted with Us to provide Benefits to You.

[Premium: The periodic fee required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of the Policy.]

[Prior Plan: The plan providing similar insurance Benefits carried by the Policyholder on the day before [the Policy's] Effective Date with Us.]

[Proof: Evidence satisfactory to Us that the terms and provisions of the Policy have been met. Proof may include but is not limited to: questionnaires, physical exams, or Written documentation and records as required by Us. Proof must be received by Us at Our [Home Office][Administrative Office]. All Proof must be given at Your expense (or that of Your representative or Beneficiary), unless otherwise specifically provided by the terms of the Policy. If any additional Proof is reasonably required by Us, [a Covered Person] may be required to give Us authorization to obtain such additional Proof. The following is a specific type of Proof referenced under the Policy:

Proof of Loss: Evidence satisfactory to Us that a person has satisfied the conditions and requirements for a benefit. Proof of Claim must establish:

1. the nature and extent of the loss or condition;
2. Our obligation to pay the claim under the Policy; and
3. the Claimant's right to receive payment.

Proof of Insurability: Evidence satisfactory to Us of a person's health and other information related to insurability which enables Us to determine whether the person can become insured, or is eligible for an increase in Coverage.]

[Provider: Any of the following to the extent they are authorized by law and duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O.); Doctor of Dentistry (D.D.S. or D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Doctor of Chiropractic (D.C.), Doctor's Assistant (P.A.), Psychologists (Ph. D.), Nurse (R.N. or L.P.N), which may include Nurse Midwife, Nurse Anesthetist, and Nurse Practitioner, a Licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.) when such Provider is not a Family Member.]

Reservist: A member of a reserve component of the Armed Forces of the United States. "Reservist" also includes a member of the Army National Guard and the Air National Guard.

Schedule of Benefits: Shows the amount of Benefits provided under this Policy.

[Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. [Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.]]

[Spouse: Your lawful Spouse who is an Eligible Dependent. [The term also includes [a registered] [Domestic Partner][civil union] who is an Eligible Dependent, where allowed by law.]

We, Us, Our, and Insurer: The insurer, Nationwide Life Insurance Company.

[Written or Writing: A record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.]

You and Your: An Insured Person.

Other terms are defined elsewhere under the Certificate.

[COVERED PERSONS PREMIUMS

When are Your Premiums due?

The first Premium for each Covered Person is due on the date [he or she becomes covered under this Policy.][he or she enrolls for insurance under the Group Policy.] Each Premium after the initial Premium is due at the end of the period for which his or her preceding Premium was paid. [See the Schedule of Benefits for the Frequency of Premium payment.]

What happens if You are late with a Premium payment?

A Grace Period of [30-90] days from the Premium due date is allowed for each Covered Person for payment of each Premium due after the initial Premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, You will be liable to us for payment of any Premium accruing during the period we continued his or her Coverage under this provision.

The Grace Period will not continue Coverage beyond a date as described in the "**When will Coverage end?**" provision.]

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

Eligible Person: An individual is eligible for Coverage if he or she is in an Eligible Class as [described in the Schedule of Benefits][defined by the Policyholder] and if he or she satisfies any Eligibility Waiting Period as [described in the Schedule of Benefits][defined by the Policyholder].

Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that You are insured under the Policy and that Dependent Coverage is provided under the Policy.

Dual Eligibility status: If both an Eligible Person and His or Her Spouse are in an Eligible Class of the Policyholder, [each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the Spouse carrying dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other Spouse's Coverage].

When do You enroll?

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. [As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must [acknowledge Your permission to the Policyholder to withhold such Premium from Your Pay][agree to make the required contributions and pay the first premium at time of enrollment.] The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.

Eligible Person: An Eligible Person who has met all eligibility requirements of the Group prior to the Effective Date of the Policy may request enrollment during the enrollment period that precedes the Effective Date of the Policy. After the Effective Date of the Policy, a [new, newly hired] Eligible Person must request enrollment [during the Eligibility Waiting Period][no later than [1-90] days after [the date of hire][the end of the Eligibility Waiting Period][the date he or she becomes eligible]. An Eligible Person who does not enroll as indicated above [will be considered a late enrollee][and][may not enroll until the next annual enrollment period unless there is a Change in Family Status, as described below].

[An Eligible Person who has met all eligibility requirements of the Policyholder may enroll at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Coverage.]

[Eligible Dependent: If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of his or her Dependents at the time he or she requests enrollment for himself per the above. If You acquire a new Dependent, as an Insured Person, You may request enrollment per the *Change in Family Status* provision below. [If Eligible Dependents are not enrolled at this time, the Dependent will be considered a late enrollee.] [The Dependent may not enroll [until the next annual enrollment period] unless there is a *Change in Family Status*, as described below.] [Proof of the Dependent relationship may be required by Us.]]

[Change in Family Status: Eligible Persons may enroll or change their Coverage if a change in family status occurs, provided an Enrollment Form is received within [1-120] days of the event. A change in family status means any of the following:

1. Marriage [or lawful domestic partnership]; and,
2. Divorce or legal separation; and,
3. Birth, adoption, or Placement for Adoption of a Child; and,
4. Death of a Spouse or Child; and
5. A court or administrative order requiring the Eligible Person to provide Coverage for his or her Child; and
6. Other changes as permitted by the Policyholder and Us.]

[Annual Enrollment: Eligible Persons may enroll themselves and their Eligible Dependents during an annual enrollment period, as specified by the Policyholder and Us.]

[If Proof of Insurability is required what do You have to do?

If an Eligible Person [or his or her Dependent] is required to give Proof of Insurability for all or a portion of his or her insurance, We will provide forms for providing such Proof and instructions for their completion.] [If Proof of Insurability is required for any Coverage, the completed Proof of Insurability statement must be sent to [Us at Our [Home Office]][Administrative Office].

When will Your Coverage begin?

[If the Policyholder requires You to contribute toward the cost of all or part of the insurance, no such Contributory insurance will become effective for You before the first premium is paid.]

Subject to [the Eligibility Waiting Period] [and] Your enrollment and payment of any Contributory portion of the premium due], Your Guaranteed Issue Amounts will become insured under the Policy at 12:01 AM at the main office of the Policyholder, as shown in the Schedule of Benefits, on Your first day of Coverage. [If You are not Actively at Work on the date Your insurance Coverage would begin, Your insurance will begin on the date You come back to Active Work.]

[If Your insurance plan is Contributory and You Sign the Enrollment Form more than [1-120] days after You became eligible, Your Contributory insurance will be deferred until the date We approve Your Written Proof of Insurability.]

[For any amount of insurance that requires Proof of Insurability, You will become insured for the additional amount of insurance retroactively at 12:01 AM at the main office of the Policyholder, as shown in the Schedule of Benefits, on the Effective Date of the Guaranteed Issue Amount when We approve Your Proof of Insurability. If We disapprove the Proof of Insurability, You are not covered for the additional amount of insurance. We will refund the Contributory portion of the premium paid for the additional amount of insurance.]

[When will Coverage begin for Your Dependents?

Subject to the enrollment procedure described above, payment of the Premium due, and satisfactory Proof of Insurability, Your Dependents will become insured on the same date and at the same time as You. If You acquire additional Dependents after Your Effective Date of Coverage and have Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be [the date We accept the new enrollment], [the first of the month following the event causing eligibility][the first of the month following] the date You complete and Sign the Enrollment Form requesting Coverage], subject to timely payment of any Premium due. If You acquire additional Dependents after Your Effective Date of Coverage and do not have Dependent Coverage, and provided You enroll Your newly Eligible Dependents as indicated above, the Effective Date will be:

1. [for Your Spouse, the first of the month following the event causing eligibility];
2. [for newborn children from [the moment of birth] [age [1-30] [day,days][month,months]]];
3. [for adopted children the date of Placement for Adoption];
4. [for all other Eligible Dependents, the date You enroll such Dependent];

[subject to payment of any Premium due.] If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such Child shall take effect on the [date of enrollment][date of the order], if We are notified in accordance with our enrollment guidelines] [and] [once the required Premium, if any, has been paid].]

[The Policyholder may require [employees, You] to contribute toward the cost of all or part of [their, Your] Dependent insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child. The form for this agreement may be obtained from the Policyholder. [If You Sign the Enrollment Form more than [1-365] days after You became eligible for Dependent insurance, such Contributory insurance will be deferred until the date We approve Written Proof of Insurability for each Eligible Dependent.]]]

[How is the Effective Date affected if Proof of Insurability is required for Your Dependent's [Basic Life] [Voluntary Life] [Basic Accidental Death [and Dismemberment]] [Voluntary Accidental Death [and Dismemberment]] Insurance?

No amount of [Life Insurance] [for a Covered Dependent] in excess of [the Guaranteed Issue Amount][$\$0$ - $\$250,000$, in [$\1],[$\$5$],[$\25],[$\$50$],[$\100],[$\$500$],[$\$1,000$], [$\$5,000$], [$\$10,000$], or [$\$25,000$] increments] shall become effective prior to Our approval of Proof of Insurability.]

[Are there situations when Your Dependents' Effective Date may be deferred?

If any Eligible Dependent, other than a newborn child, is confined due to Injury or Illness at home or in a hospital or other medical facility on the date insurance would otherwise begin, the insurance will be deferred until [[1-365] days following] the end of the Eligible Dependent's confinement.]

[You may acquire a new Eligible Dependent while Your insurance for other Dependents is in effect. If so, the new Eligible Dependent will automatically become insured, except as noted in the next paragraph.]

Your newborn Child is the only Eligible Dependent whose insurance may begin on a day that he or she is a hospital inpatient. Insurance so deferred for any other Eligible Dependent will become effective on the day he or she is discharged from the hospital.]

[In no event will coverage for an Eligible Dependent start:

- Before the Eligible Person's Coverage starts; and
- For a newborn child, before the child reaches any minimum age stated in the in the ["When will Coverage begin for Your Dependents" section] [Schedule of Benefits].]]

May You change Your Insurance at any time?

Change in family status: If You have a change in family status as described in the **When do You Enroll?** section, you may add Eligible Dependents or change Your Benefits as described below.

Annual Enrollment: [Each year] during the [annual] enrollment period You may [provided You are then Actively At Work] elect to:

1. increase Your [and Your Covered Dependent's][Basic][and][Voluntary] insurance Benefits;
2. decrease Your [and Your Covered Dependent's][Basic][and][Voluntary] insurance Benefits;
3. keep the same [Basic][and][Voluntary] insurance Benefits You currently have [for Yourself and Your Covered Dependents];
4. [obtain [Basic][and][Voluntary] insurance Benefits at the lowest level under the Policy, [for Yourself][and][Your Eligible Dependents] if not currently insured. [The Proof of Insurability provisions of the Policy will apply];
5. cancel Your [Basic][and/or][Voluntary] insurance Benefits [for Yourself][and/or][Your Covered Dependents].

[If [You are not insured for [Basic][and/or][Voluntary] Benefits and] You do not elect [to increase] the Benefits during the [annual] enrollment period, You will not be eligible to [elect][or][increase] Benefits until the following [annual] enrollment period.]

Rehire: [If You are rehired by Your employer within the same plan year that You terminated employment, You may only elect to be insured for the same amount of [Basic][and/or][Voluntary] Benefits that You were insured for on the date Your employment was terminated.]]

[Are there limits to any increase in Coverage?

[The amount of any increase in Coverage [without Proof of Insurability] under this provision will be limited to [[1%-100%, 1% increments] of the prior amount of Coverage][0-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments][.5-5, .5 increments] times Annual Earnings].]

[All increases will be subject to the maximum amount shown in the Schedule of Benefits.]]

[When will Benefits change?

[Changes in the amount of [Basic][and/or][Voluntary] Benefits will become effective[on the [last day of][first day of the Policy month next following] [first day of the new Plan Year] the [annual] enrollment period. If You elect an increased amount of [Basic][and/or][Voluntary] Benefits greater than [[1%-100%, 1% increments] of Your current amount][100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000]][.5-5, .5 increments] times Annual Earnings], that increase will be deferred until the date We approve Your Written Proof of Insurability.]

Change in Eligible Class or Earnings: The amount of Your Benefit [and/or Benefits for Your Covered Dependents] may change if You become insured under a different Eligible Class [or the amount of Your Annual Earnings changes].

[The change][If the change would *increase* the amount of insurance, the increase] takes effect on the [first day of the Policy month [in which You are Actively at Work] following the] latest of the date:

1. [the change is effective; or]
2. [You] [the Policyholder] tell[s] Us [in Writing] about a change in Class [or Annual Earnings]; or
3. [the Premium is paid based on the change.]

[If the change would *decrease* Your amount of insurance, the decrease takes effect [the first day of the Policy month [in which You are Actively at Work] following the date of the change][on the date of the change.]]

When will Your Coverage end?

All of Your insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the earliest of the following dates:

1. [The [last day of the month in] which Your employment terminates. For the purposes of insurance coverage Your employment will terminate when You are no longer Actively at Work. [However, if You are not Actively at Work due to Illness or Injury, Your insurance will be continued in force under the Policy until the earlier of:
 - a. The date on which We receive Written notice from the Policyholder that Your insurance is terminated.
 - b. The end of the [[1-36] [month, months]] period following the date on which You were last Actively at Work].]
2. The date the Policy terminates;

3. [[The date] Your [employer, company] ceases to be an Affiliated [employer, company] with the Policyholder;]
4. The [date][last day of the month] in which You cease to be an Eligible Person[,except due to a Leave of Absence];
5. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
6. The [date][last day of the month in which] We receive written notice from You or the Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;
7. The last day of the period for which premium was paid, if a premium is not paid when due;
8. The [date] [last day of the month] in which] the Policy is changed to end the insurance for Your Eligible Class;
9. [The [date][last day of the month in which] You retire unless Your insurance is continued in a retired Eligible Class [as defined by the Policyholder][as shown in the Schedule of Benefits];]
10. [For retirees, the date Your status as a retiree ends in accordance with the Policyholder's retirement plan];
11. [The [date][last day of the month in which] You enter full-time active duty in the armed forces of any country or international authority];
12. [The [last day of the month following][date of] Your [50th-99th, increments of 1] birthday;]
13. The date of Your death.

[In addition, Coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder.]

[*Leave of Absence:* Any Leave of Absence must have been authorized [in Writing] by Your Employer. All premiums otherwise required by the Policy must be paid in order for any continuance of insurance provision to be applicable.]

[If Coverage is continued in accordance with the *Leave of Absence* provisions above, such continued Coverage will cease immediately if any one or more of the following events occurs:

1. The leave terminates prior to the agreed upon date;
2. The Policy terminates [or Your employer ceases to be [an Affiliated employer of] the Policyholder];
3. You or the Policyholder fail to pay premium when due; or
4. The Policy no longer insures Your Eligible Class.]

{The following provision does not apply to any retiree class:}

[Will coverage continue after termination under any circumstances?

If Your insurance would otherwise end solely due to #[1-13] above, the Policyholder may continue Your insurance during the following periods:

1. until [the end of the [[1st-36th] month following the month] You cease to be Actively at Work due to a temporary lay-off; or
2. [until the end of the [1st-36th] month following the month] You cease to be Actively at Work due to [a Leave of Absence or due to] Your being called to active duty as a reservist with the U.S. Armed Forces Reserve; or]
3. during an absence from work due to a Leave of Absence that is in compliance with the Family Medical Leave Act.

[When will Coverage end for Your Dependent?

Your Dependent's insurance under the Policy will terminate at 12:01 AM at the main office of the Policyholder on the first to occur of the following dates:

1. The date the Policy terminates;
2. [The [date][last day of the month] the Dependent ceases to be an Eligible Dependent] or [if the Dependent ceases to be an Eligible Dependent, the earliest of:
 - a. the [date][last day of the month] the Dependent reaches his or her maximum age under the Policy; or
 - b. the [last day of the month] following a [1,2,3] year period of time from the date the Dependent lost eligibility];
3. The [date][last day of the month] in which You cease to be insured under the Policy,
4. The [date][last day of the month in which] You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which premium was paid, if a premium is not paid when due;
6. The [date][last day of the month] We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The [date] the Policy is changed to end the insurance for Your Eligible Class;
8. [The [date] that the Dependent enters full-time active duty in the armed forces of any country or international authority;]
9. [For Your Dependent Spouse [the [last day of the month following][date of][Your][His/Her] [50th-99th, increments of 1] birthday;]
10. [The [date][last day of the month in which] You retire;]
11. [The date You become insured under the Waiver of Premium provision of the Policy;]
12. The date of Your death.]

[Handicapped Dependent Children: Insurance will continue for a handicapped Child who has attained either limiting Age shown above, if such Child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting Age. Proof of incapacity must be furnished to Us within [1-365] [day,days] of attainment of the limiting Age.]

[Notice Required When Your Coverage Terminates: We must be informed within [1-365] [day,days] of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of [1-12] Policy [months, months] [or to the last Policy Anniversary, whichever is less]. If We are not notified that Your Coverage is terminated and We pay any Benefits for Your Covered Expenses incurred after the date Your Coverage terminated, [the full amount of those Benefits will be considered an overpayment which must be repaid to Us][or You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid].]

[What happens to Your insurance when You retire?

As a retiree, You are eligible for insurance under the terms of the Policy if You were Actively at Work and covered for insurance on the day immediately preceding the date of Your retirement and You have retired in accordance with the Policyholder's retirement plan.]

[What happens if You return to [Active Work][eligible status]?

After release from active duty: If Your insurance or Your Eligible Dependent's insurance ends due to Your being called or ordered to full-time active duty in the armed forces of any country or international authority, such insurance will be reinstated without any Eligibility Waiting Period when You return to Active Work.

[After [termination of employment][or][loss of eligibility]: If You [return to Active Work] [or] [meet the definition of Eligible Person] [within the same Plan Year][but no more than][within] [1-365] [day,days] of the date Your Coverage terminated][within the same Plan Year], You may [become an Insured Person][re-enroll for insurance under this Policy]. [We will waive the Eligibility Waiting Period.]]]

Do Benefits reduce due to attainment of certain ages?

Yes. Benefits reduce based on Your age [and Your Spouse's age] as shown in the Schedule of Benefits.

COVERAGE PROVISIONS

[BASIC][AND][VOLUNTARY]LIFE INSURANCE DEATH BENEFIT

What Benefits are provided to Covered Persons?

We will pay a Benefit if a Covered Person dies while covered in accordance with the provisions of the Policy. [In the event the Covered Person commits suicide, [Basic][Voluntary][any Contributory] Life insurance will be limited as described below.] [Your Life Insurance Benefits are payable to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy, upon Our receipt of due Proof of Your death.]

[Your amounts of insurance [and Your Covered Dependent's insurance] are shown on Your Schedule of Benefits. A Covered Person is not insured for any type of Coverage for which the Schedule of Benefits shows [the amount as "none"].][or for which You have not paid the required premium.]

[Your amounts of insurance [and Your covered Dependent's insurance] are determined by [the Schedule of Benefits.][the amount You elected on Your group enrollment form]. A Covered Person is not insured for any type of Coverage for which the Schedule of Benefits form shows the amount as "none".]

[The Benefit will be paid in one sum.][The Benefit will be paid in one sum unless, prior to payment, You or the Beneficiary elect that payment be made in installments. This is called a settlement option. If no settlement option is in effect upon Your death, Your Beneficiary may then elect such an option. Any settlement option requires a Written agreement with Us. Contact the Policyholder for instructions.]

[If the amount of Benefit paid is at least [\$100-\$250,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments], We will make available to Your Beneficiary a retained asset account. Payment for the life Claim may be accessed by writing a check in a single sum or retained in the account by the Beneficiary to write checks in smaller sums.]

Dependent Life Insurance shall be payable to You, if living, otherwise to Your estate, on receipt by Us at Our [Home Office][Administrative Office] of due Proof of the death of the Covered Person. You will be considered the Beneficiary for Dependent Life Insurance. [Payment will be made in one sum.] [In the event the Dependent commits suicide, [Basic][and][Voluntary][any Contributory] Life Benefits will be limited as described in the Suicide provision below.]

What happens when death is due to suicide?

No payment will be made with respect to the amount of [Basic][and][Voluntary][any Contributory] insurance under the Policy when a Covered Person commits suicide [whether while sane or insane] and death occurs within [one, two, three] [year, years] after the date on which the deceased became insured for or elected an increased amount of insurance. [[The [one, two, three]] year period includes the time Coverage was in force under a Prior Plan, provided [the Covered Person's] Coverage was in effect up until the date of such Prior Plan's termination.]

[Our liability with respect to such [Basic][and][Voluntary][Contributory] insurance of such a person will be limited to an amount equal to the premiums paid thereon.]

[CONTINUATION DUE TO [PERMANENT AND] TOTAL DISABILITY

This section tells how [some or all of] Your [Life] insurance can be continued without premiums if You become Totally Disabled before Your [50th-99th, increments of 1] birthday. [[Waiver of Life Insurance Premium][Total Disability Installment][Extended Death] Benefits apply [only] to [Basic][and][Voluntary][Life] insurance Coverage [and do not apply [to any Dependent Coverage][or][to any Accidental Death [and Dismemberment] Coverage]].]

[Waiver of Premium Elimination Period: [[1-365, increments of 1] [day, days][month, months]]

[Waiver of Premium Termination Age: Age [60-99, increments of 1]]

[If You become Totally Disabled, is there Waiver of Premium?

If You become Totally Disabled while You are insured and prior to Your [50th-99th, increments of 1] birthday then subject to the terms of the Policy and this provision, no premium payment will be required for the type(s) of insurance listed below as of the date You satisfy the Elimination Period:

1. [Your Basic Life Insurance]
2. [Your Voluntary Life Insurance]
3. [Your Accelerated Death Benefit]
4. [Your Basic Accidental Death [and Dismemberment] Benefit]
5. [Your Voluntary Accidental Death [and Dismemberment] Benefit].

[The amount of insurance will be the amount in effect as of the date You became Totally Disabled, subject to any reductions listed in the Age Reductions provision while You are Totally Disabled.]

[After We determine that You are Totally Disabled, Waiver of Premium for Life Insurance *will not* be affected by:

1. termination or cancellation of the Policy by the Policyholder; or
2. termination of Your employment; or
3. termination of Your insurance Coverage under the Policy; or
4. any amendment that is effective after the date You are Totally Disabled.]

[Premiums for Dependents' insurance Coverage will not be waived.]

[If You become Totally Disabled while You are insured and on or after Your [50th-99th, increments of 1] birthday, You will be eligible for a limited Waiver of Life Insurance Premium Benefit, subject to all other terms and conditions of the Waiver of Life Insurance Premium provision, and not to exceed the lesser of:

1. Your original amount of insurance; or
2. [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].]

[Other Coverage under the Policy for which premiums are not waived may be continued on a premium paying basis, [subject to the provisions of the When Insurance Ends section].]

[How do You receive Total Disability Installments Benefits?

If You have been insured under the Policy for at least [[1-60] [month,months]], and become Totally Disabled prior to Your [50th-99th, increments of 1] birthday and while You are insured under the Policy then, on the [earlier of] the end of [[1-36] [month,months]] of continuous Total Disability [or as of the completion of the Elimination Period], [for each \$1,000 of Your Total Disability Installment scheduled amount], We will pay You [1-120] monthly installments of [\$5-\$2,500, in [\$1] or [\$5] increments]] each to a maximum Benefit of [\$25-\$2,500, in [\$1], [\$5], or [\$25] increments].

If You die and Your death occurs before all monthly installments are due, the commuted value at [.5%-15%, .5 % increments] per annum of the remaining installments will be paid in one sum to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

[What if You become Permanently and Totally Disabled? We will waive the payment of premiums for Your [life Insurance] under the Policy and will begin paying a monthly income to You when due Proof is received at [Our Home Office] that:

1. You are then Permanently and Totally Disabled and You have been so disabled for at least [1-36 [consecutive] [month,months]];
2. You became Permanently and Totally Disabled while You were insured under the Policy and before Your [50th-99th, increments of 1] birthday;
3. [You were insured for [life insurance] under the Policy for at least [[one, two, three] [year, years]] prior to the date You became Permanently and Totally Disabled.]

Written notice that You are Permanently and Totally Disabled must be received by Us at [Our Home Office] within [1-36 [month, months]] after You ceased active work due to the disability.

The amount of [life insurance] on which premium will be waived and monthly income payments will be based, shall be determined as of the date You become Permanently and Totally Disabled. The amount will be the life insurance amount for which You were insured on that date.

The period for which premium payments for Your [life Insurance] will be waived and monthly income will be paid shall:

1. begin with the [Policy month] that follows Our receipt of due Proof that You are Permanently and Totally Disabled; and
2. continue while You remain so disabled until Your [life Insurance] amount has been paid in [1-120, increments of 1] [installment, installments], including interest on the unpaid balance at [Our policy loan interest rate then in effect.]

The amount of Your monthly income payment will be determined by a formula, which allocates [\$1-\$50, in [\$1], [\$5], or [\$10] increments] for each [\$500-\$5,000, in [\$1], [\$5], [\$50], [\$100], [\$500], or [\$1,000] increments] of the [life Insurance] amount in effect on [the date] You became Permanently and Totally Disabled, apportioned over a [[1-120, increments of 1] month] period. Any Accelerated Death Benefit paid to You will reduce Your monthly income payment.

Our liability shall be fully discharged to the extent of the aggregate amount of monthly income payments made under this provision.

If for any reason You are unable to give a valid release for any monthly income payment, We may, at our option, make such payment to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.

If You die while monthly income is being paid, the remaining monthly income installments will be paid to Your Beneficiary upon receipt at [Our Home Office] of Proof of Your death. The rate of interest on such remaining monthly installments will be based on the interest rate in effect on the date Your first monthly income installment became payable. Your Beneficiary may elect to receive the remaining installments in one lump sum.

[If You die within [[one, two, three] [year,years]] after the date You ceased active work due to becoming Permanently and Totally Disabled, but before Proof of Your disability is received by Us, Your [life Insurance] amount will be paid to Your Beneficiary provided that, within [[one, two, three] [year,years]] after Your death We receive at Our Home Office:

1. due Proof of Your death; and
2. due Proof that You were Permanently and Totally Disabled from the date You ceased active work to the date of Your death.

If a Benefit is payable under the Conversion of Life Insurance provisions, or any other provision of the Policy, the amount, if any, payable under this provision will be reduced by the amount of that Benefit.

If an individual policy was issued to You under the Conversion of Life Insurance provision, no payment will be made under this provision, unless such policy is surrendered to Us. This must be done without the payment of any Claim on the individual policy except for the refund of any premium paid on it.

If Your Benefits under this provision end in accordance with the **When will Coverage end?** provision, and You do not return to active work in an Eligible Class for life insurance under the Policy within [31] days, then You may convert the balance of Your [Life Insurance] remaining unpaid on that date. You may do this as though Your insurance had ended on such date because Your employment ended.

If Your Benefits under this provision end in accordance with the **When will Coverage end?** provision, and You do return to active work within [1-365] day[s] in an Eligible Class for [life insurance] under the Policy then, after You return to work:

1. The amount of [life] insurance for which You may be insured will be the amount determined in accordance with the Schedule of Benefits, reduced by the total of all monthly income installments that were paid under this provision; and
2. Premium must be paid for that insurance in accordance with the terms of the Policy.

Termination of the Policy will not affect Your rights under this provision if You are entitled to this Benefit because of Permanent and Total Disability, which began before the date the Policy terminated. Any Benefits which are provided under this provision after that date will not:

1. affect that termination; or
2. continue the Policy in force after that date.]

[Is there an Extended Death Benefit available due to Total Disability?

The insurance continued in force under this provision with respect to You will terminate on the earlier of: (i) the date on which You cease to be Totally Disabled or (ii) [one year] from the date on which the Policyholder ceased to make premium payments with respect to You. [However, if You are still Totally Disabled on the date on which You attain age [50-99, 1 year increments], Your amount of insurance will be [\$100-\$250,000, in [\$1], [\$5], [\$25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]. [All other provisions of the Policy, including the Termination of Benefit section of this provision, will apply.]]

[How does the conversion right work during the Waiver of Premium Elimination Period?

You may apply for an individual life insurance policy under the Conversion of Life Insurance provision of the Policy, and if Your insurance terminates before You fulfill the Elimination Period under this provision or You do not meet the Definition of Total Disability under this provision, You may retain the individual life insurance policy in accordance with that policy's provisions.

However, once You have met the conditions for [Waiver of Premium] You must surrender the individual life insurance policy in accordance with its terms and receive a refund of Your premium payments. You may not be insured simultaneously under both [this Policy] and an individual policy issued in accordance with the Conversion of Life Insurance provision.]

[How do You prove that You are Totally Disabled?

All Proof of Total Disability that We require must be given to Us at Our [Home Office][Administrative Office]. The Proof must be satisfactory to Us.

[We have the right to have You examined by a Provider of Our choosing at Our expense whenever reasonably necessary, but not more than once a year after two years of Total Disability.]

Conditions for Proof

1. We must receive initial Proof of Your Total Disability no later than [1-36] [month,months] after the date Your Total Disability began. This Proof must be satisfactory to Us.
2. If You die prior to submitting initial Proof of Your Total Disability as required in Condition 1, Proof that Your Total Disability continued until the date of Your death must be given to Us no later than [1-36] [month,months] after Your death.
3. The insurance on Your life will be subject to any reductions in amount or termination of insurance included under the Policy as of the date You satisfy the Elimination Period which would have applied to You due to Your age if You were not Totally Disabled.
4. Any amount of insurance continued in force under this provision that becomes payable will be reduced as follows:
 - a. By any amount paid under the terms of the Conversion provision of the Policy because death occurred within the [1-365] day period in which You were entitled to apply for a policy of individual life insurance.
 - b. By any amount of insurance paid under a policy that was issued to You under the Conversion provision of the Policy after You became Totally Disabled, unless such policy was surrendered to Us without Claim in exchange for a full refund of premiums paid under it.]

Does insurance terminate when You are no longer Totally Disabled?

Your insurance continued in force under this provision will terminate on the earliest of the following:

1. The date on which You cease to be [Totally Disabled].
2. Three months after the date We request further Proof that You are still Totally Disabled if such Proof is not received within this period. We may ask for further Proof as often as We may reasonably require.
3. [The date of Your [50th-99th, increments of 1] birthday.]
4. [The date on which You attain the maximum age [as shown in the Schedule of Benefits]].
5. [The date You refuse to be examined by a Physician when requested.]
6. [The date on which You begin to receive retirement benefits which You are eligible to receive as a result of past employment with the Policyholder or another employer, whether or not the retirement benefits were funded in whole or in part by the Policyholder or a previous employer or entirely by You. This also includes retirement under any federal, state, municipal, or association retirement plan.]

If the Policy is in force but either You are not in an Eligible Class [as shown in the Schedule of Benefits] insured under the Policy or You are not Actively at Work, You will be entitled to the same conversion rights that You would have been entitled to if Your insurance had terminated due to the termination of Your employment. If the Policy is not in force, You will be entitled to the same conversion rights that You would have been entitled to if Your insurance had terminated due to the termination of the Policy. The period that a conversion right will apply will be [the [1-365] [day,days] following the date the insurance under this provision is terminated.]

If Your insurance is continued in force under this provision and is then terminated because Your [50th – 99th, increments of 1] birthday has occurred, You will be entitled to the same conversion rights to which You would have been entitled had Your insurance terminated because You are no longer [an Insured] under an Eligible Class.

[Are Premiums waived for Covered Dependent insurance during Your Total Disability?

If insurance on Your life is continued in force pursuant to the CONTINUATION DUE TO [PERMANENT AND] TOTAL DISABILITY provision], then subject to the terms of the Policy and this provision, no premium payment will be required for Your Covered Dependents for the type(s) of insurance listed below:

1. [Basic Life Insurance for [Your Covered Spouse][Dependents]].
2. [[Voluntary] Life Insurance for [Your Covered Spouse][Dependents]].
3. [Your Covered Spouse's][Dependent's] Accelerated Death Benefit]
4. [Basic Accidental Death [and Dismemberment] Benefit for [Your Covered Spouse][Dependents]].
5. [[Voluntary] Accidental Death [and Dismemberment] Benefit for [Your Covered Spouse][Dependents]].

[No [Waiver for Dependent Insurance] will be continued beyond the earlier of the date:

1. the insurance would otherwise terminate in accordance with the When Insurance Ends For Your Dependent's Insurance provisions of the Policy;
2. Your [Waiver of Premium] Benefit terminates in accordance with the provisions of the Policy.]

If [the Waiver for Dependent Insurance] under this provision terminates, then:

1. if the Policy is in force, Your Covered Dependents shall be entitled to the same conversion rights to which the Dependent would have been entitled if the insurance had terminated due to the termination of Your employment.
2. if the Policy is not in force, Your Covered Dependents shall be entitled to the same conversion rights (if any) to which the Dependent would have been entitled if the insurance had terminated due to the termination of the Policy.]]

For further information, refer to the provision entitled **Conversion of Life Insurance**.

Definitions for [Waiver of Life Insurance Premium][Total Disability Installments][Extended Death] Benefit Provision:

[Elimination Period: The period that You must have been continuously Totally Disabled before We waive insurance premiums under this provision. The Elimination Period is the lesser of [[1-36] [month,months]][the time period shown in the Schedule of Benefits] or if applicable, the period of Your continuous Total Disability preceding the date of death. The Elimination Period begins on the day that You meet the Definition of Total Disability under the Policy.]

[Material and Substantial Duties: Job duties that:

1. are normally required for the performance of Your own or any occupation; *and*
2. cannot be reasonably omitted or modified.]

[Permanently and Totally Disabled: You are disabled by Injury or Illness to the extent that:

1. You cannot perform any duties of any occupation for which You are qualified by education, training or experience; *and*
2. We receive Proof that enables Us to determine that You will be continuously so disabled for life.]

[Regular Care:

1. You are under the continuing care of and personally visit a Provider as frequently as is medically required according to standard medical practice, to effectively diagnose, manage and treat Your disabling condition(s); *and*
2. You are receiving appropriate treatment and care of Your disabling condition(s) which conforms with standard medical practice by a Provider whose specialty and clinical experience is appropriate for Your disabling condition(s) according to standard medical practice.]

[Totally Disabled and Total Disability: During the Elimination Period and thereafter because of an Injury or Illness, You meet **both** of the following:

1. You are unable to perform the Material and Substantial Duties of any occupation for which You are or may become reasonably qualified by education, training, or experience; *and*
2. You are receiving Regular Care from a Provider for that Injury or Illness.

The loss of a professional license, occupational license or certification does not in itself mean You are Disabled. Loss of Your occupation due to economic factors such as, but not limited to, recession, job elimination, pay cuts and job-sharing will not be considered a disability.]

[You will not be considered to be Totally Disabled on any day that You meet the definition of Actively at Work.]

[ACCELERATED DEATH BENEFIT

What if [Your Covered Spouse][Your Covered Dependents] [or] You need money prior to death?

You may obtain proceeds from [Basic][and][Voluntary] Life with an Accelerated Death Benefit

The following Accelerated Death Benefit Provision applies [only] to Your [and Your [Covered Spouse's][Dependent's]] Coverage for [Basic][and][Voluntary][Life]Insurance:

The Accelerated Death Benefit provides that a portion of the [Basic][and][Voluntary] life insurance proceeds otherwise payable under the Policy as a result of death may be paid in advance under certain circumstances. Payment is made if You [or Your Covered Spouse][or Your Covered Dependent] [is][are] diagnosed as having a Terminal Condition, subject to the terms of the Policy and this provision. All of the following conditions will apply:

1. [Your [or Your Covered Spouse's][or Your Covered Dependent's] legal representative must request [in Writing] to have this Benefit paid while [Your][or Your Covered Spouse's][or Your Covered Dependent's] insurance is in effect.]
2. [We must be provided with the Written permission of [Your][or Your Covered Spouse's][or Your Covered Dependent's] irrevocable Beneficiary or assignee for the life insurance proceeds otherwise payable under the Policy, prior to paying this Benefit. [If [You][or Your Covered Spouse][or Your Covered Dependent] lives in a community property state, We must have Written permission of the Covered Spouse.]]
3. [You must be eligible for the Waiver of Premium Benefit For Disabled Employees included under the Policy. However, this Benefit may be payable prior to Your having satisfied the requirement of being disabled for a continuous period of [1-36 [month,months].]]
4. [At the time of application, You [or Your Covered Spouse][or Your Covered Dependent] must be under age [50-99, 1 year increments]].
5. [Premium payments must continue, and will be based on the reduced amount of Your [or Your Covered Spouse's][or Your Covered Dependent's] insurance.]
6. We must receive Proof satisfactory to Us that [[You][or Your Covered Spouse][or Your Covered Dependent]] as the applicant has been diagnosed as having a Terminal Condition.
7. You [or Your Covered Spouse][or Your Covered Dependent] must be living at the time this Benefit is to be paid.
8. Accelerated Benefits are payable only once with respect to You [or Your Covered Spouse][or Your Covered Dependent].

The amount of life insurance otherwise payable on Your [or Your Covered Spouse's][or Your Covered Dependent's] death in accordance with the other terms of the Policy will be reduced by the amount of this Benefit [plus Interest calculated from the date this Benefit is paid to the date of death]. Such reduction will also apply to any amount [You][or Your Covered Spouse][or Your Covered Dependent]would otherwise be eligible to apply for under the Conversion provision.

[If the life insurance applicable to You [or Your Covered Spouse][or Your Covered Dependent] Covered Spouse would otherwise reduce in accordance with the other terms of the Policy within [[1-36] [month,months]] of the date of application for this Benefit, then the Benefit will be based on such reduced amount. If Your [or Your Covered Spouse's][or Your Covered Dependent's] insurance would otherwise terminate within [[1-36] [month,months]] of the date of application for this Benefit, then the Accelerated Death Benefit will not be paid.]

Payment of this Benefit does not guarantee that Your [or Your Covered Spouse's][or Your Covered Dependent's]full death Benefit will eventually be paid. Insurance must still be in force under the Policy at the time of Your[or Your Covered Spouse's][or Your Covered Dependent's] death for the remainder of the life insurance Benefit to be paid. All limitations and exclusions under the Policy will still apply. Payment of the Accelerated Death Benefit discharges Us of all liability under the Policy to the extent of the payment.

Amount of Benefit

Your [or Your Covered Spouse's][or Your Covered Dependent's]Accelerated Death Benefit is an amount equal to the lesser of:

1. [1%-100%, 1% increments] of the [combined] amount of [Basic] [and] [[Voluntary] Life Insurance] to which You [or Your Covered Spouse][or Your Covered Dependent] are entitled on the date You [or Your Covered Spouse] [or Your Covered Dependent] apply[ies] [in Writing] for this Benefit; or
2. [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].

[A lesser amount of Accelerated Benefit may be elected. [However, the minimum Accelerated Death Benefit We will consider for payment is [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].]

[At the time of payment, the Accelerated Death Benefit will be reduced by an administrative charge in the amount of [\$1-\$1,000, \$1 increments]].

Payment will be made in one lump sum to You. [If You have received an Accelerated Benefit for You [or Your Covered Spouse][or Your Covered Dependent]and then such person recovers from the qualifying condition, You will not be required to refund the Benefit paid to You.]

When would an Accelerated Benefit not be available? No Accelerated Death Benefit will be payable if any of the following conditions apply:

1. The Terminal Condition is directly or indirectly due to or associated with a self-inflicted injury or suicide attempt [whether committed while sane or insane].
2. We have been notified that all or a portion of Your Life Benefits are to be paid to Your former Spouse as part of a divorce agreement.

3. [The Terminal Condition is directly or indirectly due to or associated with [the Insured] committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act.]
4. [The Terminal Condition is directly or indirectly due to or associated with alcohol or drug abuse.]

If the Accelerated Death Benefit election is forced by creditors or government agencies, We will honor it only to the extent required by law.

We reserve the right to have You [or Your Covered Spouse][or Your Covered Dependent] examined by one or more Providers of Our choice in connection with any Claim for Accelerated Death Benefit. Such an examination will be done at Our expense. Final determination of eligibility will be made by Us.

Definitions for this Accelerated Death Benefit provision:

[Interest: [The prime interest rate, as of the date the Accelerated Death Benefit is paid, plus [.5%-10%, .5% increments] percent [compounded daily]. However, in no event will the interest rate exceed the greater of:

1. the current yield on 90 day treasury bills; or
2. the current maximum statutory adjustable policy loan interest rate.][Moody's Corporate Bond Yield Averages – Monthly Average Corporates – published by Moody's Investor's Service, Inc., or any successor thereto, for the calendar month ending the month before the date [the Insured] applies for the Accelerated Death Benefit.]]

Terminal Condition: A medical condition that a Provider expects to result in Your [or Your Covered Spouse's][or Your Covered Dependent's]death within [1-36] [month,months]] from the date of application for the Accelerated Benefit and from which You [or Your Covered Spouse] [or Your Covered Dependent] are not expected to recover.]

{Note: The following [pages] are included if the Policy includes Accidental Death [and Dismemberment] Coverage.}

[BASIC [AND VOLUNTARY] ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When are Accidental Death [and Dismemberment] Benefits Paid?

Payment for any Accidental Death [and Dismemberment] Insurance Benefit will be subject to all of the following conditions:

1. The Loss is caused solely by an Accident.
2. The Loss is not excluded by the terms of the Exclusions section of this provision.
3. The Accident occurs while You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are/is insured under this provision.
4. [The Loss occurs within [1-365] [day,days] after the date on which the Accident occurred [unless otherwise specified].]
5. The maximum amount payable will be subject to the terms of the Limitations section of this provision.

[We may, at Our expense, require You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] to undergo an Independent Medical Exam so that We may determine that You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are/is eligible for Benefits under the Policy [or under any [Additional Benefit]

Definitions for Accidental Death [and Dismemberment] Insurance

The following definitions apply to the Accidental Death [and Dismemberment] Policy provisions and Benefits[, as well as any [Additional Benefits] for Accidental Death [and Dismemberment].]:

Loss: A Benefit from the Schedule of Losses [for Basic][or][Voluntary] Accidental Death [and Dismemberment] which is payable under [the Policy's] terms and conditions. [To be considered for Accidental Death [and Dismemberment] Benefits, a Loss must occur within [[1-365] [day,days]] of the Accidental [, unless otherwise specified].]

Definitions Related to this Benefit:

Loss: With regard to:

1. [an arm, leg, hand or foot, [the total and irrecoverable loss of its use, provided the loss is continuous for [1-36] [consecutive] [month,months] and such loss of use is determined to be permanent at the end of such time.][complete severance at or above the wrist or at or above the ankle]]
2. [a thumb and [index] finger or all four fingers of one hand, complete severance at or above the metacarpophalangeal joints.]
3. [all five toes, complete severance at or above the metatarsophalangeal joints.]
4. [an eye, the total and irrecoverable loss of sight.]
5. [speech, the complete and irrecoverable loss of speech.]
5. [hearing, the complete and irrecoverable loss of hearing.]
6. [Quadriplegia, the total paralysis of both upper and lower limbs provided the loss is continuous for [1-36] [consecutive] [month, months] from the date of the loss.]
7. [Paraplegia, the total paralysis of both lower limbs provided the loss is continuous for[1-36] [consecutive] [month, months] from the date of the loss.]
8. [Hemiplegia, the total paralysis of upper and lower limbs on one side of the body provided the loss is continuous for [1-36] [consecutive] [month, months] from the date of the loss.]
9. [Uniplegia, the total paralysis of one limb provided the loss is continuous for [1-36] [consecutive] [month, months] [from the date of the loss.]

Principal Sum: The amount which applies to a Covered Person under the applicable Amount of Insurance provision at the time of the Accident.

We will pay the amount described in the Schedule of Losses if [You] suffer a covered Loss due to an Accidental Injury, subject to all of the terms and limitations of the Policy:

[Schedule of Losses[For [Your] Basic [and Voluntary] Accidental Death [and Dismemberment]]]

Nature of Loss Amount Payable

[Life.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of both eyes.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either both hands <u>or</u> both feet.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[One hand <u>and</u> one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of one eye <u>and</u> either one hand <u>or</u> one foot	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Speech <u>and</u> hearing in both ears	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either one arm <u>or</u> one leg.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either one hand <u>or</u> one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of one eye or one ear.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Speech <u>or</u> hearing in both ears.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Both the thumb <u>and</u> [index] finger of one hand.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Both thumbs of both hands.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[All four fingers of one hand.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[All of the toes of one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Quadriplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Paraplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Hemiplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Uniplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]

[Your Covered Spouse's][Your Covered Dependent's] [Covered Person's] Basic [and Voluntary] Accidental Death [and Dismemberment] Benefits

We will pay the amount described in the Schedule of Losses if Your [Covered Spouse][Covered Dependent] suffers a covered Loss due to an Accident Injury, subject to all of the terms and limitations of the Policy:

[Schedule of Losses Your Covered Dependents Basic Accidental Death [and Dismemberment]]

[Life.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of both eyes.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either both hands <u>or</u> both feet.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[One hand <u>and</u> one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of one eye <u>and</u> either one hand <u>or</u> one foot	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Speech <u>and</u> hearing in both ears	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either one arm <u>or</u> one leg.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Either one hand <u>or</u> one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[The sight of one eye or one ear.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Speech <u>or</u> hearing in both ears.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Both the thumb <u>and</u> [index] finger of one hand.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Both thumbs of both hands.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[All four fingers of one hand.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[All of the toes of one foot.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Quadriplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Paraplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Hemiplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]
[Uniplegia.....	[1/8, 1/4, 1/2,,3/4] [of] The Principal Sum]

Any amount payable for Accidental Death [and Dismemberment] Benefits will be paid to You, except in the case of Your Loss of life, in which case, payment will be made to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.

The Benefit will be payable when We receive due Proof of a Loss. Your [or Your Covered Spouse's][or Your Covered Dependent's] [a Covered Person's] Principal Sum for Accidental Death [and Dismemberment] insurance is shown in the Schedule of Benefits. [The Benefit to be paid is the amount from the Schedule of Losses for [Basic[and/or][Voluntary] Accidental Death [and Dismemberment] subject to any conditions or reductions of the Policy.] If, as the result of any one Accident, You [or Your Covered Spouse][or Your Covered Dependent] [a Covered Person] suffers more than one of the Losses shown in the Schedule of Losses with respect to any one limb, payment will be made only for the Loss for which the largest amount is payable. The total maximum amount payable for all Losses will not exceed [the Insured's] Principal Sum [unless otherwise specified by any applicable Additional Benefit].

May You convert Accidental Death [and Dismemberment] Benefits upon Termination of Insurance?

No, if Your Covered Spouse] [Covered Dependents] [Basic][or][Voluntary] Accidental Death [and Dismemberment] Insurance ceases or is reduced, You cannot convert that group insurance to an individual policy.]

[Do Accidental Death [and Dismemberment] Benefits terminate upon attainment of a certain age?

Yes, benefits under the Accidental Death [and Dismemberment] Benefit terminates upon Your [or Your Covered Spouse's] [or Your Covered Dependent's] attainment of the age [shown in the Schedule of Benefits].]

Note: The following Additional Benefits may be attached to the Basic and/or or Voluntary Accidental Death & Dismemberment Policy(ies).

ADDITIONAL BENEFITS

All other provisions, limitations and exclusions remain unchanged except as specifically noted within the Benefit.

[Additional Benefit for Policyholder’s Owned, Leased, Chartered or Operated Aircraft

Losses otherwise covered under the Policy which are sustained by You while in travel or flight in a Policyholder Owned, Leased, Chartered or Operated Aircraft, including if You are acting as a licensed pilot or crew, [will not be excluded from payment][will be paid at the reduced rate of [1%-100%, 1% increments] of the amount listed from the Schedule of Losses], subject to all of the terms and limitations of the Policy and all of the following conditions:

1. The aircraft must have a valid and current airworthiness certificate, and be licensed, operated, and maintained in accordance with all appropriate state and federal government aviation standards, including but not limited to the standards of the Federal Aviation Administration; and
2. The aircraft must be operated by a licensed pilot; and
3. You must be engaged in company authorized business.

Aggregate Limit for Additional Benefit for Policyholder Owned, Leased, Chartered or Operated Aircraft: The aggregate limit is [[\$100-\$2,000,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] dollars] for any Incident. This is the maximum We will pay for all covered Losses sustained under this Additional Benefit, for any and all Covered Persons under the Policy. If the aggregate limit is not enough to pay the full Benefit for each Insured Person who suffers a loss, the per-person Benefit will be reduced in equal percentage proportions for all losses by all Insured Persons.

Definition for this Owned, Leased, Chartered or Operated Aircraft Benefit:

Incident: Any one event or series of similar events related directly or indirectly to the cause or causes which result in the Loss. Such similar events need not occur in the same time period or in the same area to be treated as one Incident under this Additional Benefit.]

[Additional Benefit for Artificial Limb or Prosthetic Device

If an Accidental Injury results in You [or Your Covered Spouse][or Your Covered Dependent] [a Covered Person] sustaining a dismemberment Loss payable under the terms of the Policy, We will pay an Additional Benefit if such Loss is listed in the following table and You [or Your Covered Spouse][or Your Covered Dependent] [a Covered Person] require(s) an Artificial Limb or Prosthetic Device.

Any payment under this Additional Benefit will be subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Reimbursement will be the lesser of the actual expenses incurred or the Maximum Benefit from the schedule below.
2. Reimbursement for all expenses incurred by You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] will not exceed a total life time maximum [per Covered Person] of [\$1-\$250,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] under this Additional Benefit.
3. The Artificial Limb or Prosthetic Device must be required based on the recommendation of a Provider.
4. Satisfactory Proof of the actual expense will be required at the time of Claim.
5. Any expenses incurred more than [[1-5] [year,years]], or for which Proof is received more than [[1-5] [year,years] plus [0-365] days]] following the date of Accidental Injury will not be eligible for reimbursement.

[Table for Artificial Limb or Prosthetic Device Benefit

Nature of Loss	Maximum Amount
One arm or hand	[\$0-\$250,000, in [\$1], [\$5], [\$25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]
One leg or foot	[\$0-\$250,000, in [\$1], [\$5], [\$25], [\$50],

	[\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]
One or both eyes	[\$0-\$250,000, in [\$1], [\$5], [\$25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]
Both arms or hands	[\$0-\$250,000, in [\$1], [\$5], [\$25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]
Both legs or feet	[\$0-\$250,000, in [\$1], [\$5], [\$25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]

The Additional Benefit will be paid in a lump sum to You.

Definition for this Artificial Limb or Prosthetic Device Benefit:

Artificial Limb or Prosthetic Device: A device worn on or in the human body to artificially replace a missing portion of the body. In the event of a covered Loss for an eye, Prosthetic Device means a device for replacement of the entire eye.]

[Additional Benefit for Child Care

[Coverage for You only]

If a Benefit due to [Your] Accidental Loss [of life] becomes payable under the Policy, We will reimburse annually the reasonable and necessary childcare expenses.

The amount of Benefit will be the [lowest of the following amounts]:

1. [The amount of childcare expenses actually incurred]; or
2. [[1%-10%, 1% increments] of Your Principal Sum]; or
3. [[\$100-\$250,000, in [\$1],[\$5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] per year per Child]; or
4. [[\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] for all years and all Covered Dependent Children.]

[The maximum period of time for which Child care Benefits will be paid is [[1-60] [month,months]] from the date of the qualifying Accident.]

The Additional Benefit is payable only if:

1. You have elected Coverage under the Policy for Dependent Child(ren); and
2. Coverage is in effect on the date of the Accidental-Loss of life; and
3. You have [a] Covered Dependent Child(ren) under the age of [1-16] for whom Child Care expenses are incurred within [[1-365] [day,days]] of the Loss of life.
4. the Child Care expenses must be necessary in order for [Your surviving Spouse] to obtain training for work or to increase earnings.]

[Child care must be provided by a licensed child care provider who is not a member of Your family or Your Spouse's family. Expenses eligible for reimbursement under this Additional Benefit include enrollment or registration fees and weekly or monthly Child care fees. In states where non-institutional Child care providers are not licensed, the Child care provider must provide His tax identification number to Us for verification of Benefits.]

In the event Your Covered Dependent Child satisfies the requirement indicated above, the Additional Benefit for Child Care will be payable to [the surviving Spouse], provided:

1. the Spouse is the legal custodian of the Child; and
2. the Child is dependent upon the Spouse; and
3. the Child resides with the Spouse.

[If there is no surviving Spouse or the Child does not reside with the Spouse, the Additional Benefit will be payable to the Child's legally appointed guardian.]

[Additional Benefit for Child Education

If a Benefit due to Your Accidental Loss of life becomes payable under the Policy, We will reimburse the reasonable and necessary expenses actually incurred according to the Additional Benefit stated below for each Covered Dependent Child who is enrolled as a Full-Time Student and is under the age of [25-32] on the date of Your death:

The Child must be:

1. in an Accredited Institution for Higher Learning above the secondary school level; or
2. at the secondary school level but who will enroll as full-time student(s) in an Accredited Institution for higher learning within [[1-365] [day,days]] after the date of Your death.

The maximum Additional Benefit for Child Education will be the [lowest of the following amounts]:

1. [[1%-10%.5% increments] of [Your] Principal Sum per year for each Dependent Child;]
2. [[[\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] per year for each Dependent Child;]
3. [[[\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] for all Dependent Children and all years;]
4. [The amount of expense actually incurred.]

[In addition, the Additional Benefit will not exceed a maximum of [[1-8] years], which must run consecutively from [Your] date of death, with respect to any one Dependent Child.]

The Additional Benefit will be reimbursed [annually] upon receipt of satisfactory Proof that the Dependent Child is attending an Accredited Institution for higher learning as a full-time student, but reimbursement will not be made for expenses incurred prior to Your death, or for room, board or other ordinary living, traveling or clothing expenses.

In the event the Dependent Child satisfies the requirements indicated above and has reached the age of legal majority, such Child will be deemed the Beneficiary with respect to Benefits payable under this Additional Benefit. If the Dependent Child satisfies the requirements indicated above, and has not yet reached the age of legal majority, the Benefit will be payable [annually] to the legal guardian of the estate of the Dependent Child, until such Child reaches the age of legal majority.]

[Additional Benefit for Child Survivor

If a Benefit due to Your Accidental Loss of life becomes payable under the Policy , We will pay a lump sum Additional Benefit of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] to each Covered Dependent Child [, at the time the Child reaches the age of legal majority].]

[Additional Benefit for Children's Dismemberment

If Your Covered Dependent Child sustains a dismemberment as a result of an Accidental Injury which results in a Loss payable under the terms of the Policy and the Schedule of Losses, We will pay an Additional Benefit of [[one, two, three] times] the Benefit normally payable from the Schedule of Losses, subject to a maximum of[\$100-\$250,000 in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments .]]

[The Additional Benefit will be paid to You, or if You are deceased, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

[Additional Benefit for Coma

If an Accidental Injury [which results in a Loss payable under the terms of the Policy], causes You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] to be in a Coma continuously for at least [1-365] [day,days] We will pay an Additional Benefit. The Additional Benefit for Coma will be payable [annually] for each month of continuous Coma, but in no event more than [[1-15] [year,years] on behalf of You [a Covered Person]. No Additional Benefit for Coma will be payable after the comatose condition has ceased, whether by death, recovery or any other change of condition. The Additional Benefit will be [the lesser of] [.5%-10%, .5% increments] of the Principal Sum for each [week, month, year] that You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are in a Coma [or [.5%-10%, .5% increments] of the difference between the Principal Sum and the amount of any Benefits paid for any loss arising out of the same Accident]. [In no event shall the total amount paid for [all Accidental Death [and Dismemberment] Benefits] for You [or Your Covered Spouse][or Your Covered Dependent] [a Covered Person] exceed the Principal Sum.]

[The Additional Benefit for a Covered Dependent will be paid to You.] [The Additional Benefit for You will be paid to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.] [The Coma Benefit will be paid to the legally appointed guardian or conservator of Your finances.]

[If, after qualifying for an Additional Benefit You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] suffer[s] another Loss covered under the terms of the Policy, due to the same Accident that caused the comatose condition, the Benefit paid for such other Loss will be the Benefit stated in the Schedule of Losses reduced by the total amount of Benefits paid, including the Additional Benefit for Coma which has been paid, with respect to You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] as a result of that Accident. If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] continue to qualify for an Additional Benefit for Coma after such other loss, the amount of Additional Benefit for Coma paid annually will be re-determined in accordance with the calculation stated above. Only one Coma Benefit will be paid for any one month of Coma, regardless of the number of injuries contributing to or causing the Coma.]

We will require [monthly,annual] Proof of the continuing Comatose condition. We retain the right to investigate to determine whether the Comatose condition exists and continues.

The Coma Benefit will be calculated at 1/30th of the monthly Coma Benefit for each day during a period of coma of less than a full month.

Definition for this Benefit for Coma:

Coma and Comatose: A profound state of unconsciousness from which You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] cannot be aroused to consciousness, even by powerful stimulation, as determined by a Provider. You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] must be confined in a medical facility during a coma.]]

[Additional Benefit for Common Carrier Accident

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] sustain[s] an Accidental Injury which results in a Loss payable under the terms of the Policy, an Additional Benefit of [1%-100%, 1% increments] of the Principal Sum will be paid, if Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Injury is sustained:

1. [while You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [is][are] boarding, riding, or exiting as a fare-paying passenger in a Common Carrier ; or]
2. [as a direct result of the burning of the [hotel], [theater], [school] or [government building] within which You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [is][are] present at the time the fire begins.]

Definition for this Benefit for Common Carrier Accident

Common Carrier: A government licensed and regulated entity that is in the business of transporting fare paying passengers. The term Common Carrier does not include:

- privately arranged transportation; or
- taxis; or
- limousines.

[Additional Benefit for Common Disaster

If a Benefit for Accidental Loss of life is payable under the terms of the Policy for both You and Your Covered Spouse and such Loss of life was sustained in a Common Accident, the [total Benefit payable for Your Covered Spouse will be increased to equal Your Principal Sum][Principal Sum for You and for Your Spouse will each be increased by [1%-100%, 1% increments]. [The Additional Benefit will be paid only to a surviving insured Dependent Child.][The Additional Benefit will be paid to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

Definition for this Benefit for Common Accident:

Common Accident: The same Accident.

[In no event will the total [combined] amount payable under [this Additional Benefit][the Policy including all Additional Benefits] exceed [\$100-\$1,000,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments]].

[Additional Benefit for Bereavement and Trauma Counseling

If a Benefit due to [Your Accidental Loss of life] becomes payable under the terms of the Policy, We will pay reasonable expenses for bereavement and trauma counseling for [You or Your immediate Family Members], subject to all of the terms and limitations of the Policy and all of the following conditions:

1. The maximum payable is [\$5-\$2,500, in [\$1], [\$5], [\$10], [\$50], or [\$100] increments] per session for up to a maximum of [[1-30] [session, sessions]]. This is a combined maximum for You and all immediate Family Members, for the same Accident; and
2. Counseling must be recommended as Medically Necessary by a Provider; and
3. Reimbursement will not be made for surgery, medications, or other medical or non medical treatment, devices or expenses, whether or not used for or in conjunction with the counseling; and
4. Satisfactory Proof that You [or Your Dependents] are receiving the counseling, and of the actual expense of such counseling will be required at the time of Claim; and
5. Any expenses incurred more than [[1,2,3] [year,years]], or for which Proof is received more than [[1,2,3] [year,years] plus [[1-365], [day,days]] following the date of Accidental Injury will not be eligible for reimbursement.

An immediate Family Member includes Your and/or Your Spouse's Children, siblings, grandparents, grandchildren. Payments for this Additional Benefit will be made to You. If You are deceased or deemed not competent to receive the Benefit by an appropriate legal authority We may pay the Benefit to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy

[Additional Benefit for Exposure and Disappearance

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [is][are]unavoidably exposed to the elements solely as the result of an Accident, and as a direct result of such exposure You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] suffer a Loss for which Benefits would otherwise be payable under the Schedule of Losses, such Loss will be covered in accordance with all other provisions of the Policy.

If, as a result of the Accidental destruction or disappearance of a conveyance in which You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are riding, You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] disappear and if the body is not found within one year of the date of the report of the disappearance, then it will be presumed that there was Loss of life due to Accidental bodily Injury.

We will only presume [an Insured] to be dead if there is no evidence to the contrary and supporting documentation from the appropriate court is provided to Us.]

[If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are later found alive after We have paid a Benefit under this Additional Benefit, the Beneficiary must repay the Disappearance Benefit to Us.]

[If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are later found dead after We have paid a Benefit under this Additional Benefit, any accidental death Benefit that becomes payable under the Policy as a result of the death will be reduced by the amount paid under the Additional Benefit for Exposure and Disappearance.]

[Additional Benefit for Victim of Felonious Assault

If an Accidental Injury which results in a Loss payable under the terms of the Policy is the result of a Felonious Assault inflicted upon You, We will pay an additional [1%-100%, 1% increments] of the Principal Sum, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. [The Felonious Assault must be inflicted by someone other than a Fellow Employee or Family Member and while You are performing Your normal work duties for the Policyholder or on Employer Premises; and]
2. A report of the criminal activity is required to have been filed with the appropriate law enforcement authority within 48 hours of the incident. A certified copy of this report must accompany the Claim for Benefits. The criminal and civil codes where the Felonious Assault or attempt was perpetrated shall be the basis for interpretation of the terms used in this paragraph.

Definitions for the Victim of Felonious Assault Benefit

[Employer Premises: A building, structure or property maintained by the Policyholder [or Associated Employer] for conducting its business operations.]

[Fellow Employee: Another [employee] of the Policyholder [or Associated Employer], whether or not insured under the Policy, and includes a former [employee] whose employment has terminated within [1-365 [day,days]] of the Felonious Assault.]

[Felonious Assault: A physical attack by another person resulting in bodily harm. A physical attack is any willful or unlawful use of force or violence with the intent to cause bodily injury. The physical attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs. The Felonious Assault must not be either a moving violation as defined under the applicable state motor vehicle laws or an act of a Family Member.]

[Additional Benefit for [Financial][Legal][and][Tax] Consultation

If a Benefit [due to Your Accidental Loss of life] becomes payable under the terms of the Policy, We will pay [the actual expenses incurred for][an amount of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] which can be used towards the cost of] consultation with a [Financial][Legal][or][Tax] Advisor [to a maximum of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments], subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Benefits are only payable under this Additional Benefit if the amount paid for Your [or Your Covered Dependent's] Loss is at least [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments];
2. The [Financial][Legal][or][Tax] Advisor must have all appropriate licenses, certifications, or qualifications which are required by law;
3. [The expense must be at the [Financial][Legal][or][Tax] Advisor's standard rate for services for which the Advisor would normally charge fees;]
4. [Satisfactory Proof of the actual expense of the consultation(s) will be required at the time of Claim.]

The Additional Benefit will be paid to You, or if You are deceased, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.

Definition for this [Financial][Legal][and][Tax] Consultation Benefit

[Financial][Legal][or][Tax] Advisor: Includes:

1. a financial planner or such person who, in return for compensation, provides advisory service with respect to management of financial resources.
2. an attorney.
3. a person such as a Certified Public Accountant tax accountant or tax return preparer experienced in tax matters and the preparation of tax returns.

The term [Financial][Legal][or][Tax] Advisor does not include any Family Member.]

[Additional Benefit for Wheelchair Confinement Expense

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] sustain[s] the Loss of [or the Loss of use] of both feet or legs or become a Quadriplegic, Paraplegic [or Hemiplegic,] [or Uniplegic] for which a Benefit becomes payable under the terms of the Policy, and You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] subsequently require(s) the use of a wheelchair to be ambulatory, We will reimburse You for the reasonable and necessary expenses actually incurred within [[1,2,3] [year,years]] of the date of the Accident causing such Loss for:

1. the cost of alterations, if any, to Your principle residence; or
2. the cost of modification, if any, to [1,2,3] motor vehicle[s] utilized by You [Your Covered Spouse][Your Covered Dependent] [a Covered Person], when such modifications are approved by the licensing authorities where required,

for the purpose of making them wheelchair accessible.

Receipts for such alteration(s) must accompany the Claim for Benefits. Payment by Us for the total of all expenses will not exceed [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] as the result of any one Accident under this Additional Benefit.]

[Additional Benefit for Line of Duty Accident

If a Loss becomes payable under the Policy for You for [Accidental Loss of life] [or Loss due to Accidental Injury], and such Loss occurs as the direct result of Injury sustained in a Line of Duty Accident while employed as a Public Safety Officer, the amount payable from the Schedule of Losses will be increased by [1%-100%, 1% increments]

Definitions for this Line of Duty Accident Benefit

Public Safety Officer: A person whose [primary] job duties include controlling or reducing crime or juvenile delinquency, criminal law enforcement, or fire suppression. Public Safety Officer includes any one or more of the following: [police officers, firefighters, corrections officers, probation officers, public transit officers, parole officers, judicial officers, and officially recognized or designated volunteer firefighters, if they otherwise meet the definition of Public Safety Officer.

Line of Duty Accident: An Accident [, including accidental exposure to adverse weather conditions,] that occurs while You are taking any action by rule, regulation, law or condition of employment that You are obligated or authorized to perform as a Public Safety Officer [in the course of controlling or reducing crime or juvenile delinquency, criminal law enforcement, or fire suppression] including such action taken in response to an emergency while off duty. [Line of Duty Accident includes an Accident that occurs while You are on duty at a social, ceremonial, or athletic function to which You are assigned or for which You are paid as a Public Safety Officer by the Policyholder, [or while going directly to, attending, or returning directly from meetings or conventions associated with Your profession.]]

[Additional Benefit for Physical Therapy Treatment

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] sustain(s) an Accidental Injury which results in a Loss payable under the terms of the Policy and such Injury requires Physical Therapy treatments, We will reimburse the reasonable and necessary expenses actually incurred by You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] for the Physical Therapy treatment, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Reimbursement for all expenses incurred by [You][a Covered Person]all Covered Persons will not exceed a total maximum under this Additional Benefit of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].
2. The Physical Therapy treatment must be recommended as Medically Necessary by a Provider.
3. reimbursement will not be made for expenses related to diagnosis, surgery, medications, medical equipment or prosthetic or assistive devices, or other medical or non medical devices, whether or not used for or in conjunction with [Your][a Covered Person's] Physical Therapy treatment.
4. Satisfactory Proof that You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] are receiving the Physical Therapy treatments, and of the actual expense of such treatments will be required at the time of Claim.
5. Any expenses incurred more than [[1,2,3] [year,years]], or for which Proof is received more than [[1,2,3] [year,years] plus [[1-365] [day,days]]] following the date of Accidental Injury will not be eligible for reimbursement.

The Additional Benefit will be paid [quarterly] to You.

Definition for this Physical Therapy Treatment Benefit

Physical Therapy Treatment: Those treatments performed by an appropriately licensed physical therapist or physiotherapist that include the use of therapeutic exercises and rehabilitative procedures, for the purpose of improving physical function and correcting or alleviating disability.]

[Additional Benefit for Rehabilitation

If You [or Your Covered Spouse] sustain an Accidental Injury which results in a Loss payable under the terms of the Policy and such Injury requires that You [or Your Covered Spouse] participate in a Rehabilitation Program in order to be qualified to engage in an occupation in which You [or Your Covered Spouse] would not have engaged except for such Injury, We will reimburse the reasonable and necessary expenses actually incurred by You [or Your Covered Spouse] subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Reimbursement for all expenses incurred by You [or Covered Spouse] will not exceed [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].
2. The Rehabilitation Program must be recommended as Medically Necessary by a Provider.
3. Reimbursement will not be made for expenses related to:
 - (a) surgery, medications, or other medical or non medical treatment, devices or expenses, whether or not used for or in conjunction with the Rehabilitation program;
 - (b) room, board, or other ordinary living, traveling or clothing expenses.
4. Satisfactory Proof that You [or Your Covered Spouse] are participating in the Rehabilitation program, and of the actual expense of such program will be required at the time of Claim.

5. Any expenses incurred more than [[1,2,3] [year,years]], or for which Proof is received more than [[1,2,3] [year,years] plus [1-365] [day,days]] following the date of Accidental Injury will not be eligible for reimbursement.

The Additional Benefit will be paid [weekly, monthly, annually] to You.

Definition for this Rehabilitation Benefit

Rehabilitation Program: A program of vocational rehabilitation acceptable to Us that will lead to returning to work for the Policyholder or another employer.]

[Additional Benefit for Repatriation

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] sustain Accidental Loss of life more than [1-1,000] miles] from Your [a Covered Person] normal place of residence and indemnity for such Loss becomes payable under the terms of the Policy, We will reimburse expenses incurred for the transportation of the body of the deceased person, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Reimbursement for all expenses under this Additional Benefit will not exceed [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments]; and
2. Eligible expenses will include transportation of the body, and charges directly related to the preparation of the body for such transportation; and
3. Transportation of the body will be to the first resting place (including, but not limited to, a funeral home or the place of interment) in proximity to the normal place of residence of the deceased; and
4. Satisfactory Proof of the actual expenses will be required at the time of Claim.

The Additional Benefit will be paid to You, or if You are deceased, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

[Additional Benefit for Seat Belt[and Air Bag] [Vehicle Safety Device]

If a Benefit due to Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Accidental Loss of life becomes payable under the terms of the Policy, We will pay an Additional Benefit, called the Seat Belt [and Air Bag Benefit], if You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] were/was wearing a Seat Belt [and the Automobile was equipped with Air Bag(s)] at the time of the Accident, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. [The [Seat Belt] Benefit equals the lesser of (i) [\$100-\$500,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] or (ii) [1%-100%, 1% increments] of the amount of the Accidental Death [and Dismemberment] Insurance Benefit paid because of [Your] Accidental death in accordance with the Schedule of Losses.]
2. [The Air Bag Benefit equals the lesser of (i) [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] or (ii) [1%-100%, 1% increments] of the amount of the Accidental Death [and Dismemberment] Insurance Benefit paid because of [Your] Accidental death in accordance with the Schedule of Losses.]
3. Satisfactory Proof that Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] death resulted from an Automobile Accident independent of all other causes, and that You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [were][was] wearing a seat belt at the time of the Accident must be received at the time of Claim. [Proof that the Automobile was equipped with Air Bags may also be required.]
4. [No payment will be made for an Air Bag Benefit if at the time of the Accident You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [were][was] not in a seat for which the Automobile provided an Air Bag, and wearing a Seat Belt.]
5. A copy of the police accident report must be submitted with the Claim. [The report must certify the position of the Seat Belt.]
6. No payment will be made for the Seat Belt [or Air Bag] Benefit for any Covered Person who is driving or riding as a passenger if:
 - (a) the blood alcohol of the driver or operator of the Automobile is in excess of [[1-100, increments of 1] milligrams of alcohol per 100 milliliters of blood]; or
 - (b) the use of any intoxicant or drug by the driver or operator or any passenger of the Automobile is determined to be a contributing cause of the Accident, whether or not the intoxicant or drug was prescribed by a Provider.

The Additional Benefit for Seat Belt [and Air Bag] will be payable to You, or in the case of [Your death, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

Definitions for this Seat Belt[and Air Bag] [Vehicle Safety Device] Benefit

[Seat Belt: A properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.]

Automobile: A motor vehicle licensed for use on public highways which is a self-propelled passenger vehicle that has four wheels and an internal combustion engine. It may include electric passenger vehicles and certain hybrids. It excludes all other motorized vehicles. [The automobile must be a personally owned vehicle.]

[Air Bag: An inflatable supplemental passive restraint system installed by the manufacturer of the Automobile that inflates upon collision to protect an individual from Injury and death.]]

[Additional Benefit for Spouse Education

If a Benefit due to Your Accidental Loss of life becomes payable under the Policy, We will reimburse the expenses incurred according to the Additional Benefit for Spouse Education stated below, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Your Spouse must have been a Covered Spouse at the time of Your [Accidental Loss of life].
2. The amount of Additional Benefit is equal to [1%-100%,1% increments] of the Principal Sum, to a maximum of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].
3. Your surviving Spouse must not have been employed at the time of the Accident.
4. Your surviving Spouse must seek full-time employment as a result of the Accident within [[1,2,3] [year,years]] of the Accident,
5. Your surviving Spouse must enroll as a Full-Time Student in an Accredited institution of higher learning for the purpose of preparing for employment within [[1,2,3] [year,years]] of the Accident.
6. Satisfactory Proof that Your Spouse has enrolled as a full-time student must be received at the time of Claim. Such Proof must be received no more than [[1, 2, 3] [year,years] plus [1-365] [day,days]] following the date of the Accident.

The Additional Benefit will be paid in a lump sum to Your surviving Spouse.]

[Additional Benefit for Surgical Reattachment

If an Accidental Injury results in You [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Loss that would otherwise be payable under the terms of the Policy, We will reimburse an amount equal to [1%-100%, 1% increments] of the amount otherwise payable from the Schedule of Losses if a dismembered part is surgically reattached. The balance of the amount that would otherwise have been payable will be paid if after [[1-365] [day,days]] the reattachment has failed to the extent that loss of use then exists.]

Satisfactory Proof of the Accidental Injury and surgical reattachment will be required at the time of Claim.]

[Additional Benefit for [Business] Travel Accident

If an Accidental Injury which results in Your Loss payable under the terms of the Policy is sustained [while traveling on company business,] We will pay an Additional Benefit of [[one-five] times] the amount shown on the Schedule of Losses subject to a maximum of [\$100-\$1,000,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments].

Definition for [Business] Travel Accident Benefit

[Traveling on Company Business: The start of a business trip whether from home or from work which ends when You return home or to work whichever occurs first. For purposes of this definition, the following do not qualify as company business:]

1. Daily commuting to and from work.]
2. [Vacation travel, including, but not limited to, a business trip which has been extended for vacation purposes. In this instance the extension including the return trip home will be excluded from Coverage.]

Satisfactory Proof that You have suffered a covered Loss under the required conditions for payment under this Additional Benefit must be received by Us at the time of Claim.]

[Additional Benefit for Occupational Training

If a Benefit due to Your Accidental Loss of life becomes payable under the terms of the Policy, We will reimburse the reasonable and necessary expenses actually incurred for an Occupational Training program for Your Covered Spouse, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. The maximum amount payable for all expenses under this Additional Benefit will be [\$100-\$250,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]; and
2. The Occupational Training must be a formal accredited program taken in order to become specifically qualified for active employment in an occupation for which Your Spouse would otherwise not have sufficient qualifications; and
3. Proof that Your Spouse is participating in an acceptable Occupational Training program, and of the actual expense of such program will be required at the time of Claim; and
4. Any expenses incurred more than [[1,2,3] [year,years]], or for which Proof is received more than [[1,2,3] [year,years] plus [1-365] [day,days]] following the date of Accidental Injury will not be eligible for reimbursement.

The Additional Benefit will be paid [weekly, monthly, annually] to Your Spouse. Payment will not be made for room, board, or other ordinary living, traveling or clothing expenses.

Definition for this Occupational Training Benefit

Occupational Training Program: A program of vocational training acceptable to Us that will lead Your Spouse to become qualified for an occupation.]

[Additional Benefit for Group Medical/Dental Continuation

If You suffer Loss of life for which Accidental Death Benefits are payable and You had the Family Plan in force, the Company will pay an additional Benefit per year equal to the lesser of:

1. the actual cost of the premium charged for continued medical and/or dental Coverage per year;
2. [1%-10%, 1% increments] of Your Amount of Insurance;] or
3. [\$100-\$250,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments].

on behalf of Your Covered Dependents who, on the date of the Accident:

1. were insured under the Family Plan; and
2. had dependent group medical and/or dental Coverage in effect which is provided through the Policyholder; and
3. subsequently elects to continue that Coverage within [1-365] [day,days] of the date of Your Loss of life.

Group Medical/Dental Continuation Benefits are payable once a year for not more than [one, two, three] consecutive [year,years] (proof of enrollment will be required) and shall terminate on the earliest of:

1. the date the Policyholder no longer makes available or terminates the group medical and/or dental plan under which such Covered Dependents are continuing Coverage;
2. the date the Covered Dependents become covered under any other group medical and/or dental plan or qualifies for Medicare;
3. the date the Covered Spouse remarries [or re-partners] (in which case this Benefit ends for all Covered Dependents);
4. the date the Covered Dependent ceases to be eligible under this Policy; or
5. the date this Policy terminates.

[Additional Benefit for In-Hospital Indemnity

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] suffer[s] a covered loss, which results in such person being confined in a Hospital within [1-365] [day,days] of the date of the Accident and if the Hospital confinement continues for at least [1-365] consecutive days, the Company will pay an additional Benefit [retroactive to the first day of confinement] equal to the lesser of:

1. [\$100-\$250,000, in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments]; or
2. [1%-100%, 1% increments] of Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Amount of Insurance

The Benefit is paid monthly for a maximum of [1-36] [month,months] as long as [You] [the Covered Person] remains confined in the Hospital. If the confinement does not last a full month, the Company will pay 1/30th of the monthly Benefit payable for each day of confinement for which the Company is liable.

Only one In-Hospital Indemnity Benefit is payable for any one day of confinement regardless of the number of covered losses incurred as the result of the same Accident.

Definition for In-Hospital Indemnity Benefit

Hospital: A place that:

1. holds a valid license;
2. is run mainly for the care and treatment of sick or injured persons as inpatients;
3. has a staff of one or more licensed physicians available at all times;
4. provides 24-hour nursing services and has at least one registered nurse on duty at all times;
5. has organized diagnostic and surgical facilities, either on the premises or on a contract basis with, and
6. is not mainly a clinic, or facility for nursing, rest or convalescence, or a place for the aged, drug addicts, alcoholics or persons with mental or nervous disorders.

[Additional Benefit for Occupational HIV

[Occupational/Employee] Coverage only.

If You contract Human Immunodeficiency Virus (HIV) or develop AIDS related Complex (ARC) during the performance of any assigned occupational duties for which compensation is received from the Policyholder, the Company will pay a Benefit equal to [1%-100%, 1% increments] of Your Amount of Insurance in effect on the date of the Accident. It will be paid in 24 equal monthly installments.

In order to receive this Occupational HIV Benefit, You must:

1. submit a workers' compensation injury report to the Policyholder within 24 hours of the Accident; and
2. submit a blood test for the Human Immunodeficiency Virus (HIV) and AIDS related Complex (ARC) within 48 hours of the Accident.

If this initial blood test is negative and You subsequently test positive for Human Immunodeficiency Virus (HIV) or AIDS related Complex (ARC) within [365] days of the Accident, the Company will begin monthly payments as described above.

[Additional Benefit for Parental Care

If You suffer Loss of life for which Accidental Death Benefits are payable, the Company will pay an additional Benefit equal to [1%-100%, 1% increments] of Your Amount of Insurance [up to a maximum of [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments]] to or on behalf of Your Dependent Parents.

The Parental Care Benefit will be payable in equal shares to the Dependent Parents. Only one Parental Care Benefit will be payable regardless of the number of Dependent Parents.

Definition for this Benefit for Parental Care

Dependent Parent(s): Your parent, parent-in-law, grandparent, grandparent-in-law, great-grandparent or great-grandparent-in-law (whether natural, step or adoptive), who is:

1. not regularly employed on a full-time basis;
2. primarily dependent upon You for support and maintenance due to a proven mental disability or physical handicap;
3. residing in Your home; and
4. eligible to be claimed as an exemption on Your federal income tax return.

[Additional Benefit for Permanent and Total Disability

If You suffer an Injury caused by an Accident which results in Your being Permanently and Totally Disabled within [1-365] [day,days] from the date of the Accident, the Company will pay a Benefit at the end of [1-36] [consecutive] [month,months] of Permanent and Total Disability equal to Your Amount of Insurance less any Accidental Death [and Dismemberment] Benefits or other Benefits payable under this Policy for any other losses incurred as a result of the same Accident.

You must provide the Company proof that You are Permanently and Totally Disabled. The Company reserves the right, at the end of the [1-36] [consecutive] [month,months] of Permanent and Total Disability to determine, on the basis of all the facts and circumstances, that You are Permanently and Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the Company's expense.

Definition for this Benefit for Permanent and Total Disability

[Permanently and Totally Disabled: You are disabled by Injury or Illness to the extent that:

1. You cannot perform any duties of any occupation for which You are qualified by education, training or experience; and
2. We receive Proof that enables Us to determine that You will be continuously so disabled for life.]

[Additional Benefit for Severe Burn

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] suffers a Severe Burn as the result of an Accident, the Company will pay a Benefit described below:

Severe Burn of at least:	Benefit: (% of Amount of Insurance)
75% of the body.....	[1%-100%, 1% increments]
50% of the body.....	[1%-100%, 1% increments]
25% of the body.....	[1%-100%, 1% increments]

The determination of whether or not an area of the body is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Provider. The Company has a right, at its own expense, to have the determination verified by a Provider of the Company's choice.

Definition for this Severe Burn Benefit

Severe Burn/Severely Burned: Cosmetic disfigurement of the surface of a body area due to an Injury caused by an Accident that is a full-thickness or third-degree burn, as determined by a Provider. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

Under no circumstances will the Company pay more than Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Amount of Insurance for all covered losses combined, including this Severe Burn Benefit, which are incurred as the result of the same Accident.

[Additional Benefit for Surviving Spouse

If You suffer Loss of life for which Accidental Death Benefits are payable [and You had the Family Plan in force,] the Company will pay an additional Benefit equal to [.5%-100%, .5% increments] of Your Amount of Insurance to [Your Covered Spouse] [Your Spouse].

[Additional Benefit for Waiver of Premium

If You suffer an Injury caused by an Accident which results in the Insured being Totally Disabled, the Company will waive Your payment of all required premiums due.

Premiums will be waived from the first premium due date on or after the date the Disability began and end on the earliest of:

1. the date You are deemed to be Actively at Work;
2. the date You cease to be covered under this Policy; or
3. the date this Policy terminates.

Definitions for this Additional Waiver of Premium Benefit

Totally Disabled and Total Disability: Because of an Injury, You meet **both** of the following:

1. You are unable to do the material and substantial duties of any occupation for which You are or may become reasonably qualified by education, training, or experience; and
2. You are receiving regular care from a Provider for that Injury.]

[PORTABILITY OF INSURANCE

[Insurance provided under this Benefit is not subject to [The Waiver of Premium Benefit,] [Extended Death Benefit,] [or Total Disability Installment for Disabled Employees]]

May You continue insurance after termination of eligibility?

Portability of insurance is the continuation of [some or all of] [the Policy's] Coverage after termination of Your employment or eligibility under Your Eligible Class while the Policy is in force. The premium for the Portable Coverage will be determined by the Policy type, Your risk classification, Our published rates in effect and Your Policy age at the time of application. [Premium rates will increase [annually on Your date of birth].] You must pay the Premium for the Portable Coverage directly to Us. You must apply for, and be eligible for, this Coverage pursuant to the following terms of this provision. Only the types of Coverage listed below are available for the Portable Coverage:

1. [Your Basic Life Insurance]
2. [Basic Life Insurance for [Your Covered Spouse][Dependents]].
3. [Your Voluntary Life Insurance]
4. [[Voluntary Life Insurance for [Your Covered Spouse][Dependents]].
5. [Your Accelerated Death Benefit]
6. [Your Spouse's Accelerated Death Benefit]
7. [Your Basic Accidental Death [and Dismemberment] Benefit]
8. [Your Basic Accidental Death [and Dismemberment] Benefit for [Your Covered Spouse][Dependents]].
9. [Your [Voluntary] Accidental Death [and Dismemberment] Benefit].
10. [Your [Voluntary] Accidental Death [and Dismemberment] Benefit for [Your Covered Spouse][Dependents]].

[Portable Coverage is not available for Covered Dependent's Coverage.][Portable Coverage is not available for Covered Dependent child(ren)]

Who may become Insured?

The Eligible Class or Eligible Classes of persons who may be insured under this provision are all of those who satisfy all of the following conditions.

1. [[You] were insured by Us [for at least [1-36] [month,months]].]
2. [Your] [the Covered Person's] life insurance provided by the other terms of the Policy has terminated due to [termination of Your employment][or] termination of [Your] Eligible Class of Coverage prior to termination of the Policy.]
3. [You] are under [50-99] years of age.]
4. [You did not terminate employment [due to a Disability] [and] [You have not attained [Your] Retirement Date].]
5. [Your [Covered Spouse][Covered Dependents] will also be allowed to apply for Portable Coverage so long as You elect Portable Coverage and the Covered Dependent(s) are under [[50-99] years of age], and are otherwise eligible under the Eligible Dependent Definition.]

How and when will insurance continue?

[You] must elect by Written application to continue Coverage under [this provision][the Group Portable Insurance Trust Policy] within the [1-365] day period immediately following the date on which [Your] insurance terminated.

If [Your] premium and application are received by Us within this period, Portable Coverage will take effect on the [2nd-366th] day immediately following the date of termination.

An application to become insured must be completed on a form approved for that purpose by Us. It must be received by Us at Our [Home Office][Administrative Office] within the [1-365] day time period.

How much insurance is Portable Coverage?

[Your][Your Dependent's] amount of Portable Coverage will be no more than [100% of] the amount of insurance in effect on the date [You] are eligible under this provision [subject to a maximum amount for any one Insured of [\$100-\$1,000,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments][less any amount converted under the Conversion provision].

[The minimum amount of Portable life Coverage is [\$100,-\$250,000, \$1,\$5,\$50,\$100,\$500,\$1,000 increments][for You], [[[\$100,-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] for Your Covered Spouse and [[[\$100,-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] for other Covered Dependents, if applicable]. If [You] are currently insured for amounts less than these minimums, [You] must apply for Portable Coverage equal to [Your] current amounts.]

[[You] may decrease [or increase] the amount of Portable Coverage, subject to the minimum [and maximum] amounts listed above. [All increases are subject to Proof of Insurability]]

[You [and/or Your Dependent(s)] may not increase [or decrease] the amount of Portable Coverage after [Your] election.]

The amount of insurance and Benefits applicable to [You] [and Your Dependents] will be shown on the Schedule of Benefits that We will issue to [You].

No amount or type of Coverage will be eligible to be continued under this Portability option unless such amount and type of Coverage is elected on the initial Written application for Portable Coverage. No amount or type of Coverage may be included in the Portable Coverage if [You] [or Your Dependent] were not insured for the same amount and type of Coverage at the time [Your] employment or eligibility under the Policy [would otherwise have] terminated and [You] became eligible for Portable Coverage.

Will there be Premium rate changes for Portable Coverage?

We may change premium rates for Portable Coverage at any time for reasons which affect Our risk assumed, including but not limited to the following:

1. Changes occur in the Coverage levels.
2. Changes occur in the overall use of Benefits by all Covered Persons.
3. Changes occur in other risk factors.
4. A new law or change in existing law that is enacted which affects the risk assumed.

The change in premium rates will be made on a class basis according to Our underwriting risk assessments. We will notify [You] [in Writing] at least [30-365] days before a premium rate is changed.]

Do Benefits reduce for Portable Coverage?

Reductions in the amount of Portable Coverage will occur in accordance with the Age Reductions [shown in the Schedule of Benefits] [outlined in the Group Portable Insurance Trust Policy]

When do Portable Coverage and Portable Coverage Eligibility end?

Any Portable coverage in effect, and all eligibility for new Portable coverage ends at 12:01 AM on the earliest date shown below:

1. On the last day of the period for which premiums have been paid in accordance with the Grace Period;
2. [On the day before [You] enter full-time active duty in the armed forces of any country or international authority;]
3. On the date on which [You] request, in Writing, to have the insurance terminated;
4. [On the date [You] attain Your Retirement Date;]
5. [[36] months from the effective date of the Portable coverage;]
6. [On Your [70th] birthday;] or
7. [On the date of the termination of the [Policy] [the Group Portable Insurance Trust Policy];]
8. On the date of Your death.]

[Any Dependent's Portable coverage in effect, and all eligibility for new Dependent Portable coverage ends at 12:01 AM on the earliest date shown below:

1. On the last day of the period for which premiums have been paid in accordance with the grace period;
2. [On the day before the Dependent enters full-time active duty in the armed forces of any country or international authority;]
3. On the date on which You request in Writing to have the insurance on Your Dependents terminated;
4. On the date on which the Dependents insurance under the Policy is no longer in force;
5. When the Dependent ceases to be an Eligible Dependent as defined [under the Policy][in the Group Portable Insurance Trust Policy];
6. On termination of Your insurance under the [Policy] [the Group Portable Insurance Trust Policy]; or
7. The date of Your death.]

[You] or [Your] legal representative must notify Us [in Writing] within [30-365] days after the date on which an event described above occurs.

Portable Coverage that has been terminated cannot be reinstated. [You] may have the right to convert [Your] Life Insurance Coverage [as described in the Conversion of Life Insurance provision of the [Policy]][as described in the Group Portable Insurance Trust Policy].

[If You elect Portable Coverage and You again become [an Eligible Person] of the Policyholder, Your Portable Coverage will end when You become eligible under [the Policyholder's Policy].]

Definitions for Portability provision:

Disability: You are unable to work and are unable to perform the substantial and material duties of Your own occupation for which You are qualified in view of age, education, experience and physical and mental capacity.

Grace Period: With respect to payment of each premium, the [1-365] [day,days] after the date on which it is due. The Portable coverage will remain in force during the Period of grace unless terminated in accordance with the Termination of Policy provision. In any event, premiums are payable for any period of grace during which the Portable coverage continues in force.

[Group Portable Insurance Trust Policy: The trust policy under which the Portable Coverage is issued. **Provisions of the Portable Insurance Trust Policy may differ from the provisions of Your Policyholder's Policy.]**

Own Occupation: The duties You regularly performed for which You were covered under the Policy immediately prior to the date Your Disability began.

Retirement Date: The date You [or Your Covered Dependent] [begin receiving retirement Benefits which You are eligible to receive as a result of past employment, whether or not the retirement Benefits were funded in whole or in part by a previous employer. This also includes retirement income from any federal, state, municipal or association plan][attain normal retirement age under the 1983 United States Social Security Act, and any amendments thereto].

Policy Age: Your age calculated by subtracting the year of Your birth from the current year as of the date of Your election.

Portable Coverage: The insurance Coverage provided, if applicable, by the [Portability of Insurance provision][Group Portable Insurance Trust Policy].

[CONVERSION OF YOUR LIFE INSURANCE BENEFITS

Who May Convert?

You will have the right to convert to an individual life insurance policy without submitting Proof of Insurability if [all or part of] Your insurance under the Policy terminates for any of the following reasons:

- [1. Your employment terminates while the Policy is in force.]
- [2. Your membership in an Eligible Class terminates while the Policy is in force.]
- [3. The Policy terminates. You must have been insured under the Policy for at least [1-10] years.]
- [4. The Policy is amended to cancel the insurance on the Eligible Class under which You were insured [as shown in the Schedule of Benefits]. You must have been insured under the Policy for at least [1-10] years.]

The policy will only be issued to You if You make a Written application to Us and the first premium due for the policy is received at Our [Home Office][Administrative Office] [Agent] within [30-365] [day,days] of such termination [or Benefit reduction]. This [30-365] [day,days] period is the conversion period. The policy will not take effect until the end of the conversion period.

If You should die during the [30-365] [day,days] conversion period, and prior to becoming insured under the conversion policy, an amount of insurance equal to the maximum amount for which You were entitled to convert will be paid as a death Benefit.

The premium for the individual policy will be determined by the policy type, the risk classification to which You belong, Our published rates in effect and Your age [(nearest birthday)] at the time of conversion.

[What type of life insurance policy is available upon conversion?

The policy may be on any plan, [other than term insurance], with level premiums and level death Benefit, which We are then issuing. [However, You may elect single premium term insurance for the policy's [first year] in force.] [It may [not] include any provision for [Disability], [Waiver of Premium], [Accelerated Death Benefits], [Accidental Death] or other special Benefit.]]

Are there limits on the amount of individual life insurance that may be obtained?

The amount of insurance You may select under the Conversion policy is subject to the following limits:

1. It may not be less than the minimum amount for which We then issue such a policy;
2. If You ceased to be insured because of reason [1 or 2] shown in the Who May Convert section of this provision, it may not be more than the amount of insurance that has been terminated, reduced by any amount of life insurance for which You may be or may become entitled under this or any group insurance policy within the conversion period;
3. [It may not exceed the amount of insurance that has been terminated less any applicable age reductions under the Policy;]
4. If You ceased to be insured because of reason [3 or 4] shown in the **Who May Convert** section of this provision, it may not be more than the smaller of the following amounts:
 - a. The amount of insurance that applied to You at the time it terminated, reduced by any amount of life insurance for which You may be or may become entitled to under any group insurance policy within the conversion period.
 - b. [\$100-\$100,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments];
5. It may not, in any event, exceed the maximum amount of insurance You are eligible to convert as stated in clause [2] or [4] above reduced by any amount of life insurance currently in force and previously converted under the Policy.

Will You receive a notice of conversion right?

The Policyholder is required to give You Written notice of Your right to convert without submitting Proof of Insurability. [If You are not given notice of the existence of the right at least [15-365] days prior to the expiration date of the [30-365] day conversion period, then You have [15-365] days after the notice is given by the Policyholder to exercise the right to convert. The additional period shall not extend beyond [1-365] [day,days] after the expiration date of the [30-365] day conversion period.] Written notice presented to You or mailed by the Policyholder to Your last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the [30-365] day conversion period, unless properly converted within said time.]

[CONVERSION OF DEPENDENT LIFE INSURANCE

Who May Convert?

If Your Covered Dependent ceases to be insured under the Dependent's Insurance provision of the Policy, he or she will have the right to buy an individual life insurance policy without submitting Proof of Insurability if [all or part of]his or her insurance terminates for any of the following reasons:

- [1. Your employment terminates.]
- [2. Your membership in an Eligible Class terminates while the Policy is in force.]
- [3. The Policy terminates. You must have been insured under the Policy for at least [1-10] [year,years].]
- [4. The Policy is amended to cancel the insurance on the Eligible Class [as shown in the Schedule of Benefits] under which You were insured. You must have been insured under the Policy for at least [1-10] [year,years].]
- [5. Your death.]
- [6. Your Covered Dependent ceases to be a Covered Dependent as defined under Eligible Dependents.]
- [7. [You become subject to the terms of the Waiver of Premium provision.]

The policy will be issued to Your Covered Dependent only if a Written application and first premium due for the policy are received by Us at Our [Home Office][Administrative Office] [Agent] within [30-365] days of such termination[or Benefit reduction].

The [30-365] day period is the conversion period. The individual policy will not take effect until the end of this conversion period.

If Your Covered Dependent should die during the [30-365] day conversion period, and prior to becoming insured under a policy again, the amount of insurance for which the Covered Dependent was entitled to convert will be paid as a death Benefit.

The premium for the individual policy will be determined by the policy type and amount, Covered Dependent's] risk classification, Our published rates in effect and the Covered Dependent's] age [(nearest birthday)] at the time of conversion.

[What type of life insurance policy is available upon conversion?

The policy may be on any plan, [other than term insurance], with level premiums and level death Benefit, which We are then issuing. [However, single premium term insurance may be elected for the policy's [first year] in force.] [It may [not] include any provision for [Disability], [Waiver of Premium], [Accelerated Death Benefits], [Accidental Death] or other special Benefit.]]

Are there limits on the amount of individual life insurance that may be obtained?

The amount of insurance that the [Covered Person] may select under the Conversion policy is subject to the following limits.

1. It may not be less than the minimum amount for which We then issue such a policy;
2. If the Covered Dependent ceased to be insured because of reason [1, 2, 5, 6 or 7] shown in the **Who May Convert** section, it may not be more than the amount of insurance that has been terminated;
3. If the Covered Dependent ceased to be insured because of reason [3 or 4] shown in the **Who May Convert** section, it may not be more than the smaller of the following amounts:
 - a. The amount of insurance that applied to the Covered Dependent] at the time it terminated, reduced by any amount of life insurance for which the Covered Dependent may be or may become entitled under this or any group insurance policy within the conversion period.
 - b. [\$100-\$100,000], in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments;
4. It may not, in any event, exceed the maximum amount of insurance the Covered Dependent is eligible to convert as stated in reason [2 or 3] above reduced by any amount of life insurance currently in force and previously converted under [the Policy.]

Will You receive a notice of conversion right?

The Policyholder is required to give [a Covered Person] written notice of the right to convert without submitting Proof of Insurability. [If [a Covered Person] is not given notice of the existence of the right at least [15-365] days prior to the expiration date of the [30-365] day conversion period, then [the Insured] has [15-365] days after the notice is given by the Policyholder to exercise the right to convert. The additional period shall not extend beyond [1-365] [day,days] after the expiration date of the [30-365] day conversion period.] Written notice presented to [the Insured] mailed by the Policyholder to the last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the [30-365] day conversion period, unless properly converted within said time.]

CLAIMS PROVISIONS

Submitting Claims and Receiving Reimbursement

How to submit a Claim: [Written notice of Claim and request for Claim forms must be given to Us within [10-365] days after the loss. Upon receipt by Us of such request, We will send Claim forms within [10-365 days] to the Claimant, Beneficiary, or You with instructions as to how they should be completed and where they should be sent. Claimants should be sure to fully complete the forms. Incomplete forms may delay the processing of the Claim.] For a Claim for loss of life, a certified copy of the death certificate must be provided to Us.

When to submit Proof of Loss: Written Proof of Loss must be provided within [30-180] days from the date of loss. We will not deny or reduce any Claim filed after [30-180] days from the date of loss if:

1. it was not reasonably possible to file the Claim within that [30-180]-day period, and
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us [in a reasonable time.] [within [1-3] [year,years] after it is due, unless You are legally incapable of doing so.]

What If additional information is required? When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

When will the Claim be paid? Indemnities payable under the Policy for any Loss will be paid as they accrue immediately upon receipt of due Written Proof of Loss.

To whom will Claims be paid? Any covered Benefit for Your Loss of life will be payable in accordance with Your Written Beneficiary designation, subject to the Policy's provisions and applicable law. Covered Benefits for all other Losses are payable to You. All payments made by Us will be made in United States dollars.

May We conduct physical examinations and autopsy?

We shall have the right and opportunity to have any Covered Person whose Injury or Illness is the basis of a Claim undergo an Independent Medical Exam. This may be done when and as often as We may reasonably require. If the person has died, We may require an autopsy, unless it is prohibited by law. Such examination or autopsy will be at Our expense.

Do We have discretionary authority for Benefit determination?

Yes, We will make the final decision on Claims for Benefits under the Policy. When making a Benefit determination, We will have discretionary authority to interpret the terms and provisions of the Policy. This discretionary authority should not be construed to limit the legal action that may be taken by a Covered Person or Beneficiary in accordance with the Legal Actions provision of the Policy, and any applicable state or federal law.]]

[May We release for payment any proceeds to persons incurring expenses related to a Covered Person's fatal condition or burial?

We may pay up to [\$100-100,000 in [\$1],[\$5],[\$25],[\$50],[\$100],[\$500],[\$1,000], [\$5,000], [\$10,000], or [\$25,000] increments] of the Life Benefit to the person We feel is entitled to payment because that person incurred expenses in connection with Your last illness, death or burial. This payment will be considered a part of the Your total life insurance Benefit.

We may perform financial audits at Our expense as often as We may reasonably require. Payment of Benefits may be contingent upon Proof of financial loss being satisfactory to Us.]

[What proof is required for Proof Of Financial Loss?

For any Benefit which is based upon determination of a person's financial loss, We shall have the right to require Written Proof of financial loss. This includes, but is not limited to:

1. statements of income;
2. tax returns, tax statements, and accountants' statements; and
3. any other Proof that We may reasonably require.]

[How are Claims for Waiver of Premium handled?

What [Proof Of Continuing Disability [for Waiver of Premium] is required? From time to time You must give Proof satisfactory to Us at Your expense that You are still Disabled. We will ask You for this Proof at reasonable intervals. We will stop [Waiver of Premium Benefits] if You do not give Proof satisfactory to Us that You are still [Totally] Disabled. We may require You to provide Us with the name and address for any Hospital, health facility or institution where You received treatment, including all attending Providers, and to give us Your [Written] authorization to obtain additional medical information, including but not limited to complete copies of medical records. We may investigate Your Claim at any time.]

[Claims for Waiver of Premium: A decision must be made within [10-365 days] after the request for review is made, unless circumstances of the Claim require an extension, in which event the decision will be made as soon as possible, but not longer than [10-365 days] after the request for review is made.

The decision will be [in Writing] and will include the reasons for the decision with reference to those Policy provisions on which it is based.]

For a [Waiver of Premium] Claim for loss due to disability, You must notify Us immediately if You return to work in any capacity.

When may information be released? [You] [and Your Spouse] agree that We may request, and anyone may give to Us, any information, (including copies of records) about a Covered Person's Illness or Injury for which Benefits are Claimed and that We may give similar information if requested to anyone providing similar Benefits to a Covered Person.]

[To whom are benefits paid for loss of life?

The Beneficiary is the person or persons You designate to receive any Benefit payable because of Your death. The designation must be made in a Written statement on a form approved by Us. [The Written statement must be placed on file with the [Policyholder] [Our Agent or Us].

You may change Beneficiaries at any time, subject to applicable law. To do so, You must provide a Written statement on a new form. The form changing the Beneficiary must be given to the Policyholder.

Any designation or change of Beneficiary will be effective on the date of its execution; regardless of whether or not You are living at the time it is given to the Policyholder. In the event You die before any designation or change is recorded, any death Benefit We may have already paid will be deducted from the amount payable to a newly named Beneficiary. [A Beneficiary may not be changed by a Power of Attorney.]

If You designate more than one person to share any death Benefit, You should specify on the form how the Benefit is to be divided among them. Otherwise, they will share the Benefit equally. All rights of any Beneficiary cease if he or she dies before You do.

If for all or part of Your insurance, no Beneficiary has been properly designated in accordance with the Policy provisions and applicable law, the amount of Your insurance for which there is no Beneficiary will be payable [to Your estate.] [in equal shares to the first of the following categories of surviving Beneficiaries:

1. legal Spouse;
2. natural, legally adopted children or placed for adoption;
3. mother and father;
4. brother and sister;
5. estate.]

If You and the Beneficiary die from the same accident, and the order of deaths cannot be determined, We will pay the Benefit as though You survived the Beneficiary.]]

EXCLUSIONS

The following exclusions apply to any and all Accidental Death] [and Dismemberment Benefits[, including any [Additional Benefits] [unless otherwise specifically referenced].

No benefit will be paid for any Accidental Death [and Dismemberment] Benefit [or under any [Additional Benefit]]for any death or Loss resulting in whole or in part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury:

1. [Suicide or any attempt at suicide while sane [or insane] [and only if it can be shown that the Covered Person intended suicide at the time of purchase of this [Policy]][Certificate][Coverage];]
2. [Intentionally self-inflicted Injury while sane [or insane], including any form of auto-eroticism;]
3. [Illness, sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these;]
4. [The medical or surgical treatment, diagnostic or preventative care of an Illness, sickness, or disease or bodily infirmity, whether the loss results directly or indirectly from the treatment, including but not limited to cosmetic surgery and gastric bypass surgery;]
5. [Infections of any kind regardless of how contracted including as the result of surgery, except bacterial infection that is the direct result of an accidental cut or wound independent and in the absence of any underlying sickness, Illness, disease or condition including but not limited to diabetes;]
6. [Travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a civil aircraft having a valid and current airworthiness certificate and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only, unless such travel is beyond the earth's atmosphere. Operating, riding in, or descending from any aircraft, if the Covered Person:
 - a. is a pilot, officer, or member of the crew of such aircraft
 - b. is giving or receiving any kind of training or instruction,
 - c. has any duties aboard or requiring descent from such aircraft, except when descent by parachute is for self-preservation;
7. [Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma;]
8. [Committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;]
9. [Voluntary poisoning in any form, including, but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol or any combination thereof;]
10. [Being under the influence of any drug, narcotic, intoxicant or chemical, unless administered by or taken according to the advice of a Provider;]
11. Participating in any activity or event, including the operation of a vehicle, while being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Provider and taken according to the Provider's instructions) [as defined by the law of the jurisdiction in which the accident occurred]. [Conviction is not necessary for determination of being "under the influence";]
12. [An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;]
13. [Participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;]
14. [Riding, driving, or testing a Motorized Vehicle used in a race or speed contest, sport, exhibition work or test driving. A Motorized Vehicle for the purpose of this provision means any self-propelled vehicle or conveyance, including [but not limited to] automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a medically necessary motorized wheelchair;]
15. [Any period while [a Covered Person] is confined to a penal or correctional institution;]
16. Participation in any riot or violent disorder.
17. [An Injury which arises out of or in the course of [Your] [a Covered Person's] employment.]

GENERAL PROVISIONS

Assignment

As part of Your estate plan, You may wish to assign ownership of any death Benefits to someone else. The Policy allows assignment of all present and future right, title, interest and incidents of ownership as to:

1. any life insurance;
2. any disability provision of life insurance; and
3. any Accidental death insurance under the Policy.

The assignment will include, but is not limited to, the rights:

1. to make any contribution required to keep the insurance in force;
2. to exercise any conversion privilege; and
3. to change the Beneficiary named.

No assignment of rights, title, interests and incidents of ownership will be binding on Us unless and until the original of the form documenting the assignment, or a true copy of it is received and acknowledged by Us at Our Administrative office.

We will have no responsibility:

1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

Changes to Policy

The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any amendment to the [Policy] must be [in Writing] and be attached to it. The amendment must bear the signature or a reproduction of the signature of the President, a Vice President, or Secretary of Our company.

[If an employee who is otherwise eligible for insurance is not Actively at Work on the Effective Date of the amendment, the Effective Date with respect to that employee will be on the date that he or she is again Actively at Work. However, if the amendment reduces the amount of insurance to which the employee is entitled, the Effective Date will be the Effective Date of the amendment.]

It is understood that, if the Policy is amended during an employee's continuous period of Disability, the amendment will have no effect on the amount of His insurance during that same continuous period of Disability.

~~[Contestability]~~~~[Incontestability]~~

We will not use misrepresentations made by a Covered Person in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during the Covered Person's lifetime, unless the misrepresentations are fraudulent. This section does not prevent Us from using at any time a defense based on:

1. non-payment of premium; or
2. any other provision of the Policy; or
3. any other defense that is allowed by law.

Errors

You must be properly Insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, or Your representative or Beneficiary, or the Policyholder.

Legal Actions

No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

Misrepresentation

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; *and*
2. Your misrepresentation is contained in a written instrument [Signed] by You; *and*
3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

Misstatement of Age or Other Facts

If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether the Covered Person should be covered and, if so, for what amount and duration.

[In addition, the life insurance premium rate will be adjusted so that the premium paid would have been correct for Your [Your Spouse's] actual age. We may make this change back to the date Coverage became effective based on the misstated information.]

Notice to Policyholder

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

Workers' Compensation Not Affected

The Policy does not replace or change any requirement for Coverage under workers' compensation insurance.

[RIDERS/NOTICES]

SCHEDULE OF BENEFITS

This Schedule of Benefits shows highlights of the coverage available under [the Group Policy]. Final interpretation of all provisions and coverages will be governed by [the Group Policy] on file with [Nationwide Life Insurance Company][at its administrative office.]

[Policyholder:	[Group Name]]
[Policy Effective Date:	[January 1, 2008]]
[Policy Number:	[111]]
[Policyholder Address:	[Address]]
[Plan Year	[Policy Year][Calendar Year]]
[Associated Companies	[Company name(s)]
[Insured Person:	[name]]
[Certificate Effective Date:	[January 1, 2007]]
[Covered Dependents	[named spouse, children, domestic partner]]
[Covered Dependents Effective Date:	[January 1, 2007]]
[Initial Term:	[12 Months]]
[Eligible Classes:	[As defined by the Policyholder – insert eligibility requirements here]]
[Eligibility Waiting Period:	[[1-365] [day,days] from the first day of Active at Work]] [during an open enrollment period agreed to by the policyholder and Us]]
[Frequency of Premium Payment:	[Weekly, Bi-weekly, Monthly, Quarterly, Semi-annually,Annually or [Coincident with Policyholder payroll cycle]]
[Method of Premium Payment:	[Remitted by Policyholder to Us] [and/or] [Remitted by Insured Person to Us]]
[Premium Due Date:	[1 st thru 31st]]
[Total Maximum Amount of Life Insurance:	[\$1,000 – \$5,000,000, [\$1], [\$5],[25], [\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000] increments] [[.5-10, .5 increments] times Annual Earnings] [The total of the Insured Person’s [Basic] [and] [Voluntary] Life Insurance will not exceed this limit.]

[BASIC TERM LIFE INSURANCE

[Amount of the Insured Person’s Basic Life Insurance

[The Insured Person’s Schedule of Benefits shows the Insured Person’s amount.]

[An amount equal to [[.5-10, increments of .5] times the Insured Person’s Annual Earnings], [rounded to the next higher [\$1, \$5, \$50, \$100, \$500, \$1,000, \$5,000, \$10,000, \$25,000], if not already a multiple thereof,] to a maximum of [\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[The Insured Person’s amount is [[\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[An amount equal to [.5-10, .5 increments] times earnings plus an amount of [\$1,000-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]

[Minimum Benefit Amount: [\$1,000 - \$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]

[The Insured Person’s amount of Basic Life Insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

[Guaranteed Issue Amount [For the Insured Person’s Basic Life Insurance]

[The Insured Person’s Guaranteed Issue Amount is [\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

<u>[Age at Enrollment</u>	<u>Guaranteed Issue Amount</u>
[Less than [60]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]
[Age [60] to [69]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]
[Age [70] or over]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]

[Proof of Insurability Requirement:

[Proof of Insurability is required for all amounts of insurance.]

[Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] times Annual Earnings].]

[Proof of Insurability is required for combined amounts of Basic and Voluntary Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] times Annual Earnings].]

[For employees under age [50-99, 1 year increments], Proof of Insurability is required for combined amounts of Basic and Voluntary Life Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] Annual Earnings].]

[For employees age [50-99, 1 year increments] or older, Proof of Insurability is required for combined amounts of Basic and Voluntary Life Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] Annual Earnings].]

[Proof of Insurability will be waived for any amount for which application is received within [[30-365] days] after [the Policy's] effective date, if the same amount and type of coverage was in force for the [Insured Person] under the prior insurance carrier's plan on the date that plan ended.]

[Proof of Insurability is required for any amount for which application is received more than [[30-365] days] after the [Eligible Person] is initially eligible to purchase the insurance.]

[Proof of Insurability is required for any increase in insurance in excess of [[\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] if the increase is due to a salary change.]

[Proof of Insurability is required for any election if the amount is increased by more than [[one, two, three, four, five, six] [level, levels][[[.5-10, .5 increments], times] Annual Earnings].]

[Waiver of Premium Elimination Period: [[1-365, increments of 1] [day,days] [month, months]]
[Waiver of Premium Termination Age: Age [50-99, 1 year increments]]]

[Amount of the Insured Person's Dependent's Basic Life Insurance

[For the Insured Person's Spouse: The lesser of [\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or [1%-100%, 1% increments] of the Insured Person's amount of Basic Life Insurance. [The Insured Person's Spouse's amount of Basic Insurance will be subject to any reductions listed in the Age Reductions provision of this Schedule of Benefits.]]

[For the Insured Person's Child: The lesser of [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or [1-100%, increments of 1%] of the Insured Person's amount of Basic Life Insurance. [Coverage is not available for Children under the age of [1-365] [day,days].]]

[[For each Child whose age is:
[[[1-19] years or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[1-12] [months] but less than [1-19] years][100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[1-365] days but less than [1-12] months][100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[[[from live birth to less than [1-365] days] [100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]]

[For each Child whose age is:
[[[1-12] months or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

[[[1-365] days but less than [1-12] months][\\$100-\$250,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[Guaranteed Issue Amount [For the Insured Person's [Dependent's][Spouse's] Basic Life Insurance

[The Insured Person's [Dependent's][Spouse's] Guaranteed Issue Amount is [\$100-\$250,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

<u>[[Age at Enrollment</u>	<u>Guaranteed Issue Amount</u>
[Less than [60]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]
[Age [60] to [69]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]
[Age [70] or over]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]

[Proof of Insurability Requirement:

[Proof of Insurability is required for all amounts of insurance.]

[Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings].]

[Proof of Insurability is required for combined amounts of Basic and Voluntary Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings].]

[For Eligible Dependents under age [50-99, 1 year increments], Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5]] Annual Earnings].]

[For Eligible Dependents age [50-99, 1 year increments] or older, Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[\\$25],[\\$50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5]] Annual Earnings].]

[Proof of Insurability will be waived for any amount for which application is received within [[30-365] days] after [the Policy's] effective date, if the same amount and type of coverage was in force for the [Insured Person] under the prior insurance carrier's plan on the date that plan ended.]

[Proof of Insurability is required for any amount for which application is received more than [[30-365] days] after the [Eligible Person] is initially eligible to purchase the insurance.]

[Proof of Insurability is required for any increase in insurance in excess of [[\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] if the increase is due to a salary change.]

[Proof of Insurability is required for any election if the amount is increased by more than [[one, two, three, four, five, six] [level, levels][[[[.5-10, .5 increments], times] Annual Earnings].]]

AGE REDUCTIONS

[The following age reduction rules apply to Your [and Your Spouse's] Basic Life

[Your amount of insurance[, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, 1 year increments]]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, 1 year increments]][the reduced Benefit amount].]

[Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

[Age	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	Benefit Amount
[Age	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[After	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[After	[1-99, 1 year increments]	[1 year	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

[Reduced amounts of Life Insurance will be rounded to the next higher multiple of [\$1-\$1,000, increments of 1], if not already such a multiple.]

[[Employee] insurance benefits reduce to [1%-100%, increments of 1%] at age [50-99, 1 year increments], further reducing to [1%-100%, increments of 1%] of the original amount of insurance at age [50-99, 1 year

increments]. Insurance then reduces by an additional [1%-100%, increments of 1%] of the original amount each subsequent year until it equals [1%-100%, increments of 1%] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain][Your Spouse attains] age [50-99, 1 year increments].]

[BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

[Principal Sum Amount of the Insured Person's Basic Accidental Death and Dismemberment Insurance

[The amount of the Insured Person's [Basic] Accidental Death and Dismemberment [Principal Sum] shall [equal] [equal [.5-10, increments of .5] times] the Insured Person's amount of [Basic] Life insurance.]

[Minimum Principal Sum Benefit Amount: [[[\$1,000 - \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[An amount equal to [[1-10, increments of 1] times the Insured Person's Annual Earnings], [rounded to the next higher [\$1, \$5, \$50, \$100, \$500, \$1000], if not already a multiple thereof,] to a maximum of [\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[The Insured Person's amount is [[[\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[The Insured Person's amount of Basic Accidental Death and Dismemberment insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

See the Schedule of Losses and Nature of Loss in the Benefit for any benefit reduction in the Principal Sum.

[Principal Sum Amount of the Insured Person's Dependent's Basic Accidental Death and Dismemberment Insurance

[For the Insured Person's Spouse: [The lesser of [\$1-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or] [1%-99%, increments of 1%] of the Insured Person's amount of Basic Accidental Death and Dismemberment Insurance.] The Insured Person's Spouse's amount of Basic Accidental Death and Dismemberment insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

[For the Insured Person's Child: [The lesser of [[[\$1-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or] [1%-99%, 1 % increments] of the Insured Person's amount of Basic Accidental Death and Dismemberment Insurance.]

[[For each Child whose age is:

[[[1-19] years or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-12] [months] but less than [1-19] years][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-365] days but less than [1-12] months][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[For each Child whose age is:

[[[1-12] months or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[[1-365] days but less than [1-12] months][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]

[The amount of the Insured Person's [Dependent's] [Basic] Accidental Death and Dismemberment [Principal Sum] shall [equal] [equal [.5-10, increments of .5] times] the [Dependent's] amount of [Basic] Life insurance.]

See the Schedule of Losses and Nature of Loss in the Benefit for any benefit reduction in the Principal Sum.

AGE REDUCTIONS

[The following age reduction rules apply to Your [and Your Spouse's] Basic Accidental Death and Dismemberment

[Your amount of insurance[, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, 1 year increments]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, 1 year increments]][the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

[Age	% of Coverage Reduction	Benefit %	Benefit Amount
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]
[After [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]
[After [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]

[Reduced amounts of AD&D Insurance will be rounded to the next higher multiple of [\$1-\$1,000, increments of 1], if not already such a multiple.]

[[Employee] insurance benefits reduce to [1%-100%, increments of 1%] at age [50-99, 1 year increments], further reducing to [1%-100%, increments of 1%] of the original amount of insurance at age [50-99, 1 year increments]. Insurance then reduces by an additional [1%-100%, increments of 1%] of the original amount each subsequent year until it equals [1%-100%, increments of 1%] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain][Your Spouse attains] age [50-99, 1 year increments].]

[Basic Accidental Death and Dismemberment Termination Age: [Age [50-99, 1 year increments]]]

[VOLUNTARY TERM LIFE INSURANCE

[Voluntary Life Insurance must be elected in accordance with the terms of the Policy [and any required premium must be paid in order for the insurance to begin].]

[Amount of the Insured Person's Voluntary Life Insurance

[The Insured Person's Schedule of Benefits shows the Insured Person's amount.]

[An amount equal to [[.5-10, increments of .5] times the Insured Person's Annual Earnings], [rounded to the next higher [\$1, \$5, \$50, \$100, \$500, \$1000], if not already a multiple thereof,] to a maximum of [\$1,000 – \$5,000,000, increments of \$1, \$5, \$50, \$100, \$500, \$1000].]

[Amounts of Insurance [above [\$1,000-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]] can not exceed [.5-10, increments of .5] times Annual Earnings.]

[The Insured Person's amount is [\$1,000-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[An elected amount in increments of [1,000-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] to a maximum of [1,000-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

[Minimum Benefit Amount: [1,000 - \$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

[The Insured Person's amount of Voluntary Life Insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

[Guaranteed Issue Amount [For the Insured Person's Voluntary Life Insurance]

[The Insured Person's Guaranteed Issue Amount is [\$1,000 - \$1,000,000, \$1, \$5, \$50, \$100, \$500, \$1,000 increments].]

<u>[Age at Enrollment</u>	<u>Guaranteed Issue Amount</u>
[Less than [60]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]]
[Age [60] to [69]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]]
[Age [70] or over]	[\$1,000 - \$1,000,000.

increments of [\$1],
[\$5],[25],[50], [\$100],
[\$500], [\$1,000], [\$5,000],
[\$10,000], [\$25,000] [[.5-10,
increments of .5] times
Annual Earnings] [None]]

[Proof of Insurability Requirement:

[Proof of Insurability is required for all amounts of insurance.]

[Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] times Annual Earnings].]

[Proof of Insurability is required for combined amounts of Basic and Voluntary Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] times Annual Earnings].]

[For employees under age [50-99, 1 year increments], Proof of Insurability is required for combined amounts of Basic and Voluntary Life Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] Annual Earnings].]

[For employees age [50-99, 1 year increments] or older, Proof of Insurability is required for combined amounts of Basic and Voluntary Life Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [[.5-10, increments of .5] Annual Earnings].]

[Proof of Insurability will be waived for any amount for which application is received within [[30-365] days] after [the Policy's] effective date, if the same amount and type of coverage was in force for the [Insured Person] under the prior insurance carrier's plan on the date that plan ended.]

[Proof of Insurability is required for any amount for which application is received more than [[30-365] days] after the [Eligible Person] is initially eligible to purchase the insurance.]

[Proof of Insurability is required for any increase in insurance in excess of [[\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] if the increase is due to a salary change.]

[Proof of Insurability is required for any election if the amount is increased by more than [[one, two, three, four, five, six] [level, levels] [[[.5-10, .5 increments], times] Annual Earnings].]

[Waiver of Premium Elimination Period: [[1-365, increments of 1] [day,days] [month, months]]

[Waiver of Premium Termination Age: Age [50-99, 1 year increments]]

[Amount of the Insured Person's Dependent's Voluntary Life Insurance

[For the Insured Person's Spouse: [The lesser of [[[\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or [1%-100%, 1% increments] of the Insured Person's amount of Voluntary Life Insurance.] [An elected amount in increments of [\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] to a maximum of [[[\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].] [The Insured Person's Spouse's amount of Voluntary Insurance will be subject to any reductions listed in the Age Reductions provision of this Schedule of Benefits.]]

[For the Insured Person's Child: The lesser of [[[\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or [1%-100%, 1% increments] of the Insured Person's amount of Voluntary Life Insurance. [Coverage is not available for Children under the age of [1-365] [day,days].]]

[[For each Child whose age is:

[[[1-19] years or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-12] [months] but less than [1-19] years][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-365] days but less than [1-12] months][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]]

[For each Child whose age is:

[[[1-12] months or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-365] days but less than [1-12] months][[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]]

[Guaranteed Issue Amount [For the Insured Person's [Dependent's][Spouse's] Voluntary Life Insurance

[The Insured Person's [Dependent's][Spouse's] Guaranteed Issue Amount is [\$1,000-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

<u>[[Age at Enrollment</u>	<u>Guaranteed Issue Amount</u>
[Less than [60]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]]
[Age [60] to [69]]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]]
[Age [70] or over]	[\$1,000 - \$1,000,000. increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings] [None]]]

[Proof of Insurability is required for all amounts of insurance.]

[Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings].]

[Proof of Insurability is required for combined amounts of Basic and Voluntary Insurance [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]][[.5-10, increments of .5] times Annual Earnings].]

[For Eligible Dependents under age [50-99, 1 year increments], Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]][.5-10, increments of .5] Annual Earnings].]

[For Eligible Dependents age [50-99, 1 year increments] or older, Proof of Insurability is required for all amounts [including any increases] in excess of [\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]][.5-10, increments of .5] Annual Earnings].]

[Proof of Insurability will be waived for any amount for which application is received within [[30-365] days] after [the Policy's] effective date, if the same amount and type of coverage was in force for the [Insured Person] under the prior insurance carrier's plan on the date that plan ended.]

[Proof of Insurability is required for any amount for which application is received more than [[30-365] days] after the [Eligible Person] is initially eligible to purchase the insurance.]

[Proof of Insurability is required for any increase in insurance in excess of [[\$0-\$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]] if the increase is due to a salary change.]

[Proof of Insurability is required for any election if the amount is increased by more than [[one, two, three, four, five, six] [level, levels]]][[.5-10, .5 increments], times] Annual Earnings].]

AGE REDUCTIONS

[The following age reduction rules apply to Your [and Your Spouse's] Voluntary Life

[Your amount of insurance [, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, 1 year increment]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, 1 year increment]][[the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

[Age [Age [1-99, increments]	[1 year	[% of Coverage Reduction [0%-100%, 1% increments]]	[Benefit % [0%-100%, 1% increments]]	[Benefit Amount [\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, increments]	[1 year	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, increments]	[1 year	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, increments]	[1 year	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, increments]	[1 year	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[After [1-99, increments]	[1 year	[0%-100%, 1% increments]]	[0%-100%, 1% increments]]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

		[\$5,000], [\$10,000], [\$25,000]]]
[After [1-99, 1 year [0%-100%, 1% increments]] [0%-100%, 1% increments]]		[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]

[Reduced amounts of Life Insurance will be rounded to the next higher multiple of [\$1-\$1,000, increments of 1], if not already such a multiple.]

[[Employee] insurance benefits reduce to [1%-100%, increments of 1%] at age [50-99, 1 year increments], further reducing to [1%-100%, increments of 1%] of the original amount of insurance at age [50-99, 1 year increments]. Insurance then reduces by an additional [1%-100%, increments of 1%] of the original amount each subsequent year until it equals [1%-100%, increments of 1%] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain[Your Spouse attains] age [50-99, 1 year increments].]

[VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

[Voluntary Accidental Death and Dismemberment Insurance must be elected in accordance with the terms of [the Policy] [and any required premium must be paid in order for the insurance to begin].]

[Principal Sum Amount of the Insured Person's Voluntary Accidental Death and Dismemberment Insurance

[An amount equal to [.5-10, increments of .5] times the Insured Person's Annual Earnings, [rounded to the next higher [\$1, \$5, \$50, \$100, \$500, \$1000], if not already a multiple thereof,] to a maximum of [\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]].

[The Insured Person's amount is [\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[An elected amount in increments of [\$1,000 – \$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] to a maximum of [\$1,000 – 5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].]

[The amount of the Insured Person's Voluntary Accidental Death and Dismemberment [Principal Sum] shall [equal] [equal [.5-10, increments of .5] times] the Insured Person's amount of [Voluntary] Life insurance.]

[The Insured Person's amount of Voluntary Accidental Death and Dismemberment insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

See the Schedule of Losses and Nature of Loss in the Benefit for any benefit reduction in the Principal Sum.

[Principal Sum Amount of the Insured Person's Dependent's Voluntary Accidental Death and Dismemberment Insurance

[For the Insured Person's Spouse: [[The lesser of [\$1,000 – \$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] or] [1%-100%, 1% increments] of the Insured Person's amount of Voluntary Accidental Death and Dismemberment Insurance.]] [An elected amount in increments of [\$1,000 – \$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] to a maximum of [\$1,000 – \$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]].] [The Insured Person's Spouse's amount of Voluntary Accidental Death and Dismemberment insurance will be subject to any reductions listed in the Age Reductions provision shown in this Schedule of Benefits.]

[For the Insured Person's Child: [The lesser of [\$1,000 – \$1,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]] [or] [1%-100%, 1% increments] of the Insured Person's amount of Voluntary Accidental Death and Dismemberment Insurance.]

[[For each Child whose age is:

[[[1-19] years or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500],
 [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[1-19] years but less than [1-19] years]..[\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-12] [months] but less than [1-19] years][100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-365] days but less than [1-12] months][100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]]

[For each Child whose age is:

[[[1-12] months or older][\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[[1-365] days but less than [1-12] months][100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
 [[from live birth to less than [1-365] days] [\$100-\$250,000, increments of [\$1], [\$5],[25],[50], [\$100],
 [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]]]

[The amount of the Insured Person's [Dependent's] Voluntary Accidental Death and Dismemberment [Principal Sum] shall [equal] [equal [.5-10, increments of .5] times] the [Dependent's] amount of [Voluntary] Life insurance.]

See the Schedule of Losses and Nature of Loss in the Benefit for any benefit reduction in the Principal Sum.

AGE REDUCTIONS

[The following age reduction rules apply to Your [and Your Spouse's] Voluntary Accidental Death and Dismemberment

[Your amount of insurance], and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, 1 year increments]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, 1 year increments]]][the reduced Benefit amount].]

[Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

[Age	% of Coverage Reduction	Benefit %	Benefit Amount
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]
[Age [1-99, 1 year increments]	[0%-100%, 1% increments]	[0%-100%, 1% increments]	[\$0-\$5,000,000, increments of [\$1], [\$5],[25],[50], [\$100], [\$500], [\$1,000], [\$5,000], [\$10,000], [\$25,000]]]



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

On Your Side®

[Nationwide Specialty [WorkPlace] BenefitsSM] [POLICYHOLDER][EMPLOYER] APPLICATION

Application is hereby made for the Benefits set forth herein.
The information given below shall be the basis of the agreement with the Plan Sponsor.

Section I - Administrative Information

Company Name					
DBA Name					
Policyholder Street Address (No P.O. Box)		City	State	Zip	County
Mailing Address (if different from above)		City	State	Zip	County
Phone ()	Administrative Contact				
Fax ()	Title				
Employer's Tax Identification Number		Email Address			
Requested Effective (MM/[DD][01]/YYYY)		Business Start Date			
Describe the Nature of Business				SIC Code	
[Will any of the selected coverage types be a takeover for an existing [group] coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify coverage types _____ Effective date of prior coverage types _____ Prior Carrier Name _____ Termination date of prior coverage types _____]					
[List names and addresses of all affiliates, branches or subsidiaries on a separate sheet of paper and submit with this application. Billing Arrangements: Are there multiple units/locations to be billed separately? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Number of units _____ <input type="checkbox"/> Bill to Individual Units <input type="checkbox"/> Bill to Plan Sponsor]					

Section II - Eligibility Requirements

1. [In order to apply for this coverage, your company must have minimum of [51] total [eligible] employees.] [Total number of [eligible] employees _____]
2. [[Eligible full-time employees must work at least [X] hours per week, must be actively at work, and must satisfy any applicable waiting period.]] [Total number of [eligible] full-time employees _____.]
3. [Are part-time employees eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No] [If yes, eligible part-time employees must work at least [X] hours per week, must be actively at work, and must satisfy any applicable waiting period.]] [[Total number of [eligible] part-time employees _____]
4. [Total number of COBRA participants _____]
5. [Total number of retirees _____] [Note: Seasonal employees, contractors, employees of employee leasing firms or employees of professional employee organizations are not eligible.]
6. [Waiting Period <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Number of days <input type="checkbox"/> 0 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other _____] [Waiting Period applies to: <input type="checkbox"/> Employees hired after the effective date] <input type="checkbox"/> All Employees (including those hired prior to the effective date) [Do different classes have a different waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____] [Note: New hires will be effective on the first of the month following completion of the waiting period.]

Section III – Product Selection

Please indicate the benefits you have selected.

<input type="checkbox"/> [Product Name]			
<input type="checkbox"/> [Product Name]			
<input type="checkbox"/> [Product Name]			

Section IV – Contributions

[Employer] [Policyholder] contribution percentage:

[[Product Name] _____ %]			
[[Product Name] _____ %]			
[[Product Name] _____ %]			

Section V - General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. [Payment of the first premium by the policyholder after delivery of the Policy by us shall constitute acceptance of the terms and conditions contained in the Policy so issued.]
2. [All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Policy and shall be furnished to us by the Policyholder.]
3. [This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.]
4. [All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.]
5. [Benefits are not provided unless otherwise provided in the Policy; (a) in case of bodily injury or sickness arising out of or in the course of any employment for wage or profit; or (b) for any bodily injury or sickness for which the person on whom the claim is presented has or had a right to compensation under Workers' Compensation or similar occupational disease law.]

Policyholder (herein referred to as “We”) responsibilities under this policy

We agree (1) to maintain the records necessary to the administration of the Policy(s); (2) to report additions, changes, terminations and other information necessary to the administration of the Policy(s) to the insurer within 31 days after the Effective Date of such additions, changes and terminations; (3) that if we do not notify the insurer of any insured ineligibility or termination within [31] days, we shall forfeit any premium refund/credit that would otherwise have been due; (4) to make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the insurer available upon request to the insurer or its authorized representative; (5) to notify the insurer of claims within [20] days after they are incurred; (6) to pay all premiums in accordance with the terms of this Policy; and (7) to notify all Employees of any termination or rescission of coverage which affects them and refund the appropriate premium.]

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for the Nationwide Life Insurance Company Policy and the proposed Policyholder understands and agrees that it shall be subject to the provisions set forth herein.

It is understood that all of the answers We have provided are representations and not warranties.

BEFORE SIGNING THE APPLICATION, PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State Fraud Notices (continued)

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please Sign and Date

Dated at _____ this _____ day of _____, _____ / ____ / ____
 City and State Date Month Year

By _____ Printed name of Employer Job Title
 Signature of Employer

[Employer’s Signature witnessed by (must be 18 or older):

 Signature of Witness Printed name of Witness Date]

[Signature of Agent/Producer:]

 Signature of Agent/Producer Printed name of Agent/Producer Date]

Section VI - Producer Information

Company/Brokerage Name		
Company Address (if different than above) City, State Zip		
Name of Agent Representing this Group		
Phone () -	Fax () -	Email Address
Producer Number		

Send Completed Application to:
 [Nationwide Specialty [WorkPlace] BenefitsSM, PO Box 1199, Newark, OH 43058-1199]



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Evidence of Insurability Form

On Your Side®

Section I – Employer Information (Please print in ink or type)

Group Number		Employer Name		
Employee Name/Member#		Class		
Employer Address		City	State	Zip Code

Section II – Employee Information

Last Name, Suffix (e.g., Sr., Jr.)		First Name		M/I	State of Birth	Date of Birth (MM/DD/YYYY)	
Residence Address				City	State	Zip Code	
Home Phone #				Work Phone #			
Gender (M/F)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated		[Social Security #]	Height (feet' & inches")		Weight (lbs)	
Occupation or Job Title				Hire Date (MM/DD/YYYY)			
Amount of Coverage Requested:				Reason for request:			
i. Employee Basic Term Life		[Current Amount:] \$ _____	Requested Amount: \$ _____	[i. New member applying for coverage		<input type="checkbox"/> Yes	<input type="checkbox"/> No
[ii. Dependent Basic Term Life		\$ _____	\$ _____	[ii. Coverage requested above guarantee issue limit		<input type="checkbox"/> Yes	<input type="checkbox"/> No
[iii. Employee Voluntary Term Life		\$ _____	\$ _____	[iii. Late Enrollee		<input type="checkbox"/> Yes	<input type="checkbox"/> No
[iv. Dependent Voluntary Term Life		\$ _____	\$ _____	[iv. Change in Family Status		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section III – Dependent Information

Relation	Last Name, First, MI (Suffix, e.g., Sr, Jr)	[Social Security#] (XXX-XX-XXXX)	Date of Birth (MM/DD/YYYY)	Height (' ")	Weight (lbs)	State of Birth	Gender (M/F)	Full-Time Student	Eligible Income Tax Exemption
Spouse [*]				' "	lbs				
Child				' "	lbs			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				' "	lbs			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				' "	lbs			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				' "	lbs			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child				' "	lbs			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

[*For purposes of this form, Spouse includes a Domestic Partner [or civil union partner]

Section IV – Medical Questionnaire

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term “medical or social practitioner” includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, clergy, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

1. Are you or any of your dependents currently pregnant? YES NO

If yes, who? _____ Expected due date(s): _____

2. Have you or any of your dependents smoked or used tobacco in the past 5 years? YES NO

If yes, who and when? _____ Type(s)? _____

3. In the past 10 years, has anyone ever:
- a. Had high blood pressure or high cholesterol? YES NO
 - b. Had heart disease, cancer, diabetes, arthritis, or asthma? YES NO
 - c. Had epilepsy? YES NO
 - d. Had back or spinal disorders? YES NO
 - e. Had a disorder of the stomach, intestines, liver, gallbladder or rectum (gastrointestinal disorder)? YES NO
 - f. Had a disorder of the kidney, bladder, prostate or reproductive organs (genito-urinary disorder)? YES NO
 - g. Had a respiratory or lung disorder? YES NO
 - h. Had a stroke? YES NO
 - i. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? YES NO
 - j. Been treated for alcohol or chemical dependency, or been convicted of driving under the influence of alcohol or drugs? YES NO

4. Has anyone ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? YES NO

5. In the past 10 years, has anyone ever had an inpatient admission and/or outpatient surgery? YES NO

6. In the past 3 years, has anyone been prescribed medication? YES NO

7. In the past 5 years, has anyone contemplated an operation or doctor visit for an existing injury or ailment? YES NO

8. During the past 3 years, has anyone sought medical treatment, or been advised by a medical or social practitioner to seek treatment, for any condition not stated above? YES NO

9. Has anyone ever been rated or declined for, or refused reinstatement or renewal of, life, disability, or health insurance? YES NO

If yes, name of person, date and reason:

10. In the past 3 years, has anyone been engaged in or does anyone contemplate being engaged in any potentially hazardous sports or hobbies such as aviation, scuba diving, bungee jumping, mountain climbing, sky diving, motor racing, or similar activities? YES NO

11. Has anyone ever received pension or worker's compensation benefits or other payment because of an injury, sickness or disability? YES NO

If you answered YES to any question in questions 3 through 11, please provide details below. If additional space is needed, please attach a separate page including your signature and date.

Question #	Name of Individual	Name of Illness or Injury	Dates of Treatment	Any Remaining Effects?	Name of Medication and Dosage	Name and Address of Physician / Hospital

AGREEMENT AND AUTHORIZATION

I understand that, in order for Nationwide Life Insurance Company or any of its subsidiaries or affiliates to accept or decline this application, all of the information requested on the application must be completed. In the event that I have not correctly or fully completed this application, my signature shall authorize Nationwide Life or any of its subsidiaries or affiliates to obtain the necessary information for me and to complete that information on this application. I realize that Nationwide Life or any of its subsidiaries or affiliates reserves the right to accept or decline this application (or to accept only certain persons for coverage) and that no right whatsoever is created by this application.

For the purpose of evaluating my application for insurance, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me, or my health, or of my family for whom this insurance application is made or their health to give Nationwide Life or any of its subsidiaries or affiliates or its reinsurers any such information. I also authorize Nationwide Life or any of its subsidiaries or affiliates or its reinsurers to release any information regarding me or my health, or that of my family for whom insurance application is made, to the Medical Information Bureau, Inc.; or other life insurance companies in which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Nationwide Life or any of its subsidiaries or affiliates to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization will be valid from the date signed for a period of twenty-four months. A photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy.

I certify that I have read, or have had read to me, the completed application and that all information is true and complete to the best of my knowledge. I understand that any misrepresentation or significant omission may void my coverage. I acknowledge that I have received the Fair Credit Reporting Notice.

PLEASE READ THE FRAUD WARNING(S) APPLICABLE TO YOUR STATE(S) BELOW AND CONTINUED ON THE NEXT PAGE.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(District of Columbia) It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.”

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(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***Includes any adult over age 18 applying for coverage.**

SIGNATURE OF APPLICANT

DATE

SIGNATURE OF SPOUSE / DOMESTIC PARTNER (if applicable)

DATE

Nationwide Life Insurance Company

INVESTIGATIVE CONSUMER REPORTS

To provide insurance coverage, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information that is related to a claim or a civil or criminal proceeding.

If we use an independent reporting agency for a report, you have the right to be personally interviewed by them. If you wish to be interviewed, please tell us how the agency can contact you and every effort will be made to interview you. Even if you are not interviewed, you have the further right to request that the reporting agency provide you with a copy of the report it makes. Write us at the address shown below and we'll give you the name and address of any agency we have used to prepare a report on you so that you can contact them directly to find out more about that report.

If you want a more detailed explanation of our information practices, please write to us at:

Nationwide Life Insurance Company
[P.O. Box 2399
Columbus, Ohio 43216]

This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance:

- A. An investigative consumer report may be made whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry will include information as to character, general reputation, personal characteristics and mode of living, with respect to you, members of your family and other having an interest in or closely connected with the insurance transaction; and
- B. Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided. Request for additional information should be directed to the same address as shown above, under NOTICE OF INSURANCE PRACTICES.

IMPORTANT NOTICE

The underwriting process is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including statements in the application and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. Nationwide Life Insurance Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life, disability or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is:

[P.O. Box 105, Essex Station
Boston, Massachusetts 02112
Telephone number (617) 426-3660.]

Nationwide Life Insurance Company, or its reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life, disability or health insurance, or to whom a claim for benefits may be submitted.

NATIONWIDE LIFE INSURANCE COMPANY
One Nationwide Plaza
Columbus, Ohio 43215-2220

Wellness and/or Health Care Services Endorsement

General Information Regarding this Endorsement

This Insured's Wellness and/or Health Care Services Endorsement ("Endorsement") revises the terms and conditions of the policy to which it is attached. To the extent the terms of the policy and this Endorsement are inconsistent, the terms of this Endorsement shall control. Non-defined terms shall have the meaning given to them in the policy.

There is no additional charge or required Premium for programs or services offered pursuant to this Endorsement.

Purpose

The purpose of this Endorsement is to inform the Policy Owner that, from time to time, we may offer the Insured access to certain health and/or wellness programs and services.

Programs and Services

The programs and services may include, but are not limited to, access to service provider referral networks, benefit consultation services and/or wellness programs. Such programs and/or services will be offered on all eligible policies on a uniform and not unfairly discriminatory basis.

We may arrange for third party service providers to administer such program or service.

All terms and conditions regarding the program or service, if any, are determined by the third party service provider. We are not liable for negligent acts or omissions of such third party service providers. Participation in such program or service is voluntary.

Availability

Programs and services provided under this Endorsement are subject to availability and may be modified, suspended, or terminated providing you with written notice.


President

SERFF Tracking Number: NWLC-126115288 State: Arkansas
 Filing Company: Nationwide Life Insurance Company State Tracking Number: 42128
 Company Tracking Number: NSHGTL 2000
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: NSHGTL 2000 et al
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Fleasch & Compliacne Certifications attached Attachments: Certification for REG 19 & 49.pdf Readability Certification - Group Life.pdf</p>		
<p>Satisfied - Item: Application Comments: Enrollment and Policyholder Application provided under forms schedule.</p>		
<p>Satisfied - Item: Statment of Variability Comments: Attachment: EOVS - Life-ADD.pdf</p>		
<p>Satisfied - Item: Authorization Letter Comments: Attachment: Authorization letter.pdf</p>		
<p>Satisfied - Item: Cover letter</p>		

SERFF Tracking Number: *NWLC-126115288* *State:* *Arkansas*
Filing Company: *Nationwide Life Insurance Company* *State Tracking Number:* *42128*
Company Tracking Number: *NSHGTL 2000*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.500 Other*
Product Name: *NSHGTL 2000 et al*
Project Name/Number: /

Comments:

Attachment:

AR Submission Letter.pdf



Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43216

RULE AND REGULATION 19 CERTIFICATION RULE AND REGULATION 49 CERTIFICATION

This is to certify that the referenced forms comply with the provisions of Rule and Regulation 19 AND 49 as well as all applicable requirements of the Arkansas Insurance Department.

For Nationwide Life Insurance Company

Tom DeNoma

Printed Name of Company Officer

Associate Vice President

Title

April 15, 2009

Date Signed

READABILITY CERTIFICATION

Name and Address of Insurer:

Nationwide Life Insurance Company
5525 Parkcenter Circle
Dublin, OH 43017-3584
Mail Code: CO-01-30

<u>Policy/Certificate</u>	<u>Form Number(s)</u>	<u>Flesch Score:</u>
NSHGTL 2000	Master Policy	67.3
NSHGTL 2500	Certificate of Coverage	62.8
NSHGTL 2500-SCHED	Schedule of Benefits	65.9

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the laws of the State of .



Melissa D. Gutierrez
Vice President
Nationwide Life Insurance Co.

Date: **April 8, 2009**

STATEMENT OF VARIABILITY
NATIONWIDE LIFE INSURANCE COMPANY
Group Term Life and AD&D Filing

NSHGTL 2000 – Policy

- All wording that is bracketed will either be in or out. No new wording will be added.
- Numerical ranges are also included throughout the forms. We will not go outside of the listed ranges when offering coverage.
- The policy will be issued to employer groups. Employees can also choose voluntary coverages.
- Policyholder -- Actual name of policyholder will be substituted.
- Effective Date -- Actual effective date will be substituted.
- Policy Number -- Actual policy number will be substituted.
- Policyholder Address – Actual policyholder address will be substituted.
- First Policy Anniversary – Actual first policy anniversary date will be substituted.
- Subsequent Policy Anniversary – Actual subsequent policy anniversary date will be substituted.
- State or Other Jurisdiction of Issue – Actual state or other jurisdiction of issue will be substituted.
- Eligible Classes- if applies, as defined by the Policyholder

NSHGTL 2500 - CERTIFICATE OF COVERAGE

- All wording that is bracketed will either be in or out. No new wording will be added.
- Numerical ranges are also included throughout the forms. We will not go outside of the listed ranges when offering coverage.

NSHGTL 2500-SCHED - CERTIFICATE OF COVERAGE

- All wording that is bracketed will either be in or out. No new wording will be added.
- Numerical ranges are also included throughout the forms. We will not go outside of the listed ranges when offering coverage.

NSHEMP 2300 - Employer Application

- Section II question #1 – Number of eligible employees are 51-100 in increments of 1.
- Section II question #2 – hours per week are 2-40 in half hour increments.
- Section II question #3 – hours per week are 2-40 in half hour increments
- Section II question #6 – Waiting period can be 0 to 365 days. We anticipate that employers will generally choose between 0, 30, 60, or 90 days.
- Section III – Product Selection – We purposely kept this application generic. Our intent is to use this application for multiple products. Products include, but are not limited to life, limited medical, major medical type products, accident only products, hospital indemnity, etc. If we intend to add a new product that will use this application, we will reference this filing.
- Section IV – Employer Contributions – Contributions will be 0-100% in 1% increments.

NSHGTL 2800-1 – Evidence of Insurability Form

- All wording that is bracketed will either be in or out. No new wording will be added.
- Numerical ranges are also included throughout the forms. We will not go outside of the listed ranges when offering coverage.



Jonna L. Shields, Compliance Specialist
5525 Parkcenter Circle CO-01-30
Dublin, Ohio 43017
PH: 614-854-3049 FAX: 614-854-3469
shieldj@nationwide.com

Office of Chief Legal Officer

March 25, 2009

To Whom It May Concern:

Coulter & Associates is hereby authorized to submit rate, rule, and form filings on behalf of **following companies:**

Nationwide Life Insurance Company, NAIC # 66869, FEIN – 31-4156830
National Casualty Company, NAIC # 11991, FEIN - 38-0865250

This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed to be in effect until rescinded in writing.

Please direct all correspondences and inquiries related to this filing to Coulter & Associates at the following address:

State Filings Department
Coulter & Associates
379 Princeton Hightstown Rd
Cranbury, NJ 08512
Phone: 609-443-1811
Fax: 609-443-4103

Please contact me if you have any questions regarding this authorization.

Very truly yours,

A handwritten signature in black ink that reads "Jonna Shields".

Jonna Shields
Compliance Specialist
614.854.3049
614.854.3469
shieldj@nationwide.com



Susan B. Coulter, CLU, ChFC
Contracts and Compliance Consultant

379 Princeton-Hightstown Rd.
Cranbury, NJ 08512
Phone: 609-443-7540
Fax: 609-443-4103
Email: susan@coulter-and-associates.com

April 14, 2009

Arkansas Insurance Department
Via Serff

Attn: Group Life Section

RE: Nationwide Life Insurance Company • NAIC #66869 • FEIN 31-4156830
Employer Group Term Life Product
Forms: NSHGTL 2000 – Policy Form
NSHGTL 2500 – Certificate of Coverage
NSHGTL 2500-SCHED – Schedule of Benefits
NSHEMP 2300 – Policyholder Application
NSHGTL 2800-1 – Evidence of Insurability Form
Authorization to File
Certification of Regulations 19 & 49

Dear Madam or Sir:

On behalf of Nationwide Life Insurance Company, Coulter and Associates is hereby submitting the referenced forms for your review and approval for use.

This is a general use filing for Nationwide's group term life product. This product will be marketed only to qualified large employer groups in your state.

These forms are new and do not replace any forms previously approved by your department.

The forms listed provide:

- basic renewable term life benefits
- optional supplemental term life benefits
- optional accidental death and dismemberment benefits
- optional accelerated death benefits

Variable text is bracketed throughout the document. Such text will either be included or excluded. Bracketed time frames will allow for variations shown and will comply with your state minimum requirements.

The forms have been filed concurrently in Nationwide's domicile state of Ohio.

We trust you will find this submission complete and these forms to be acceptable for use in your state. Please do not hesitate to contact me should you have any questions or concerns.

Sincerely,

Ms. Susan B. Coulter, CLU, ChFC
Consultant