

SERFF Tracking Number: GRJR-126226065 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number: 42933
Company Tracking Number: CLI8630
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Form CLI-8630 Payroll Deduction Disability Income Insurance
Project Name/Number: Point of Sale Advertising/Point of Sale Advertising

Filing at a Glance

Company: The Cincinnati Life Insurance Company

Product Name: Form CLI-8630 Payroll Deduction Disability Income Insurance SERFF Tr Num: GRJR-126226065 State: ArkansasLH

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 42933

Sub-TOI: H21.000 Health - Other

Co Tr Num: CLI8630

State Status: Approved-Closed

Filing Type: Form

Co Status: Submitted

Reviewer(s): Rosalind Minor

Authors: Jennifer Henley, Deborah Naegele, Karen Eichler

Disposition Date: 07/21/2009

Date Submitted: 07/15/2009

Disposition Status: Approved-

Implementation Date Requested: On Approval

Closed

Implementation Date:

State Filing Description:

State Filing Description:

General Information

Project Name: Point of Sale Advertising

Status of Filing in Domicile: Not Filed

Project Number: Point of Sale Advertising

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/21/2009

Explanation for Other Group Market Type:

State Status Changed: 07/21/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

FEIN: 31-1213778

NAIC: 0244-1075

Subject: The Cincinnati Life Insurance Company

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Point of Sale Advertising

Form CLI-8630, Payroll Deduction Disability Income Insurance

For Use With: Form CLI-508 (5/04) Disability Insurance Policy, previously approved by your department on November 23, 2004.

Dear Madame or Sir:

The above-captioned form is being submitted for your review and approval. This form is new and will not replace any other form.

The form we are filing may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document but we assure that its content will not change.

I would greatly appreciate your approval at your earliest convenience. Thank you for your usual courtesy and cooperation.

Sincerely,

Karen Eichler AIS, API
Life Systems Analyst
Life Forms Administration
The Cincinnati Life Insurance Company
Phone: 513-870-2000 x-4386
Fax: 513-881-8984

Company and Contact

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Filing Contact Information

Karen Eichler AIS, API, karen_eichler@cinfin.com
 P. O. Box 145496 (513) 870-2000 [Phone]
 Cincinnati, OH 45250-5496 (513) 881-8984[FAX]

Filing Company Information

The Cincinnati Life Insurance Company CoCode: 76236 State of Domicile: Ohio
 6200 S. Gilmore Road Group Code: 244 Company Type:
 Fairfield, OH 45014 Group Name: State ID Number:
 (513) 870-2654 ext. [Phone] FEIN Number: 31-1213778

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? Yes
 Fee Explanation: \$25.00 per advertising form X one
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Life Insurance Company	\$25.00	07/15/2009	29203721

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/21/2009	07/21/2009

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Disposition

Disposition Date: 07/21/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Payroll Deduction Disability Income Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CLI-8630

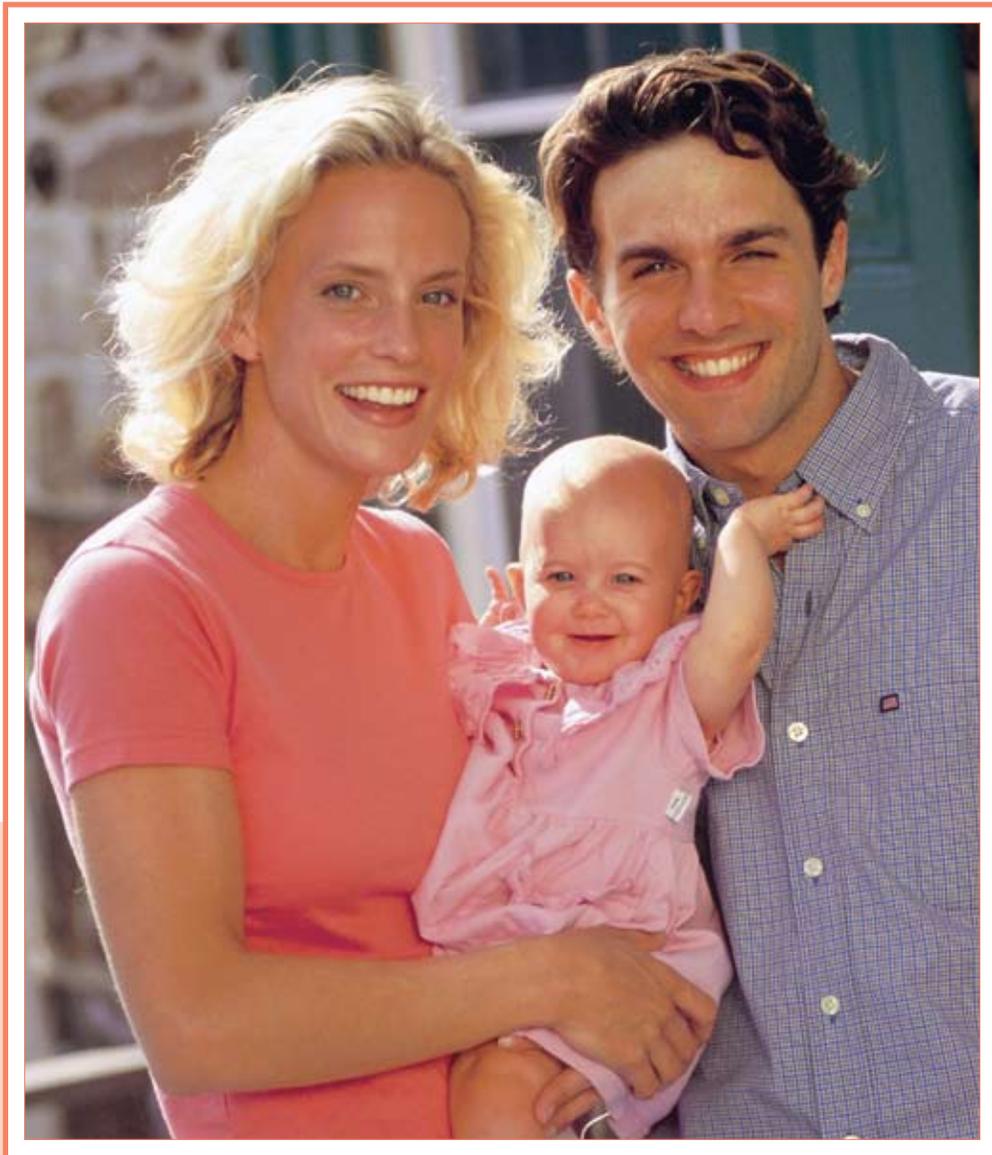
Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	Form CLI-8630	Advertising	Payroll Deduction Disability Income Insurance	Initial		0	Form CLI8630.pdf



Quality Insurance for You

Payroll Deduction Disability Income Insurance

Policy Form CLI-508



**THE
CINNATI LIFE INSURANCE COMPANY**

According to the Commissioner's Disability Table, 80 percent of U.S. workers would exhaust their savings within two months if they lost the ability to earn an income. With disability income* insurance, you and your family can still maintain your lifestyle until you're back at work.

Disability income insurance might be right for you if:

- A few weeks of missed work would make it hard to keep up with bills, such as mortgage/rent, car payments, utilities and credit card payments; or
- You have other policies, but all expenses won't be covered; or
- You get hurt while not at work. Workers' compensation may cover you on the job, but according to National Safety Council about 36 percent of the disabling injuries suffered by workers in 2006 occurred off the job.

Here's how to get started:

- You choose to participate
- Your premiums are conveniently deducted from your paycheck
- You own the policy

You choose to participate

The Payroll Deduction Disability Income insurance program is voluntary, which means you choose whether or not to purchase coverage. You choose the amount of your disability benefits to meet your needs, subject to income.

Consider these facts:

- Three in 10 workers entering the work force today will become disabled before retiring. (Social Security Administration, Fact Sheet 2007)
- At age 30, long-term disability is four times more likely than death. (*The National Underwriter 2008 Field Guide*)
- Close to 90 percent of disabling accidents and illnesses are not work related. (*National Safety Council, Injury Facts 2008 Ed.*)

Your premiums are conveniently deducted from your paycheck

You pay your premiums through convenience of payroll deduction, so there's no more worrying about writing checks or mailing payments.

You own the policy

Cincinnati Life's disability income insurance policy provides individual coverage, and you are the owner of your policy. Your policy is portable, which means if you leave your employer or retire, you can take it with you and continue to pay the same premium.

Features

Affordable insurance protection

Coverage is available to employees ages 18 through 69. Premiums are based on your age as of the policy date and the requested amount of coverage.

No medical exams required

You can apply for coverage by completing a simple application, and no medical exams are required. Your coverage becomes effective on the date you sign the application, provided you are accepted under Cincinnati Life's underwriting rules.

Guaranteed renewable coverage

Your policy is secure; Cincinnati Life cannot cancel it. Your policy is guaranteed renewable through age 69 with the same benefits as long as you pay your premiums in a timely manner. Premiums may be increased, but only if they are increased for an entire class of policyholders. Your benefits are not reduced by social insurance benefits.



*Available in most states and industries.

Optional rider*

On-the-Job Accident Rider (CLI-612)

- Eligibility – available to company employees ages 18 through 69
- Modifies the base policy to provide 100 percent of the monthly benefit if you suffer a disability resulting from an on-the-job accident prior to your 70th birthday while the rider is in effect
- Pays 50 percent of the monthly benefit if you are receiving worker's compensation or state disability income benefits

What we don't cover

Preexisting Conditions

You are not covered for a medical condition or symptoms of a medical condition for which you have done any of the following, or for which a reasonable and prudent person would ordinarily have done any of the following, at any time during the 12-month period just before the effective date of your insurance:

- consulted a health care practitioner;
- received medical treatment or services; or
- taken insulin or prescribed drugs or medications.

Definitions

Total Disability, first 12 months

You are considered totally disabled during the first 12 months of disability following the elimination period if you are unable, as a result of your medical condition, to perform the substantial and material duties of your own occupation; while you are under the regular care of a health care practitioner; and you are not working.

Total Disability after 12 months

You are considered totally disabled after receiving benefits for 12 months if you are unable, as a result of your medical condition, to perform the substantial and material duties of any reasonable occupation; while you are under the regular care of a health care practitioner; and you are not working.



Partial Disability

You are considered partially disabled if you are working in your own occupation or a reasonable occupation and you are unable, as a result of a medical condition, to work at least 50 percent of the regular schedule per week that you are worked prior to total disability, or 25 hours per week, whichever is less; you received at least 30 days of total disability benefits under this policy; and you are under the regular care of a health care practitioner.

Presumptive Disability

You are considered totally disabled if, as a result of your medical condition, you suffer:

- Complete loss of speech;
- Complete loss of hearing in both ears;
- Complete loss of sight in both eyes; or
- Complete loss of the use of both hands; both feet; or one hand and one foot.

You must be under the regular care of a health care practitioner. You receive benefits from the first day of disability.

Waiver of Premium

Your premiums are waived after 90 days of continuous disability. Any premiums you paid during the 90-day period are refunded. This benefit is included in your policy.

Disability Income Work Sheet

Determine Your Needs

Please complete this section for your one-on-one meeting with a Cincinnati Life representative.

	Your expenses	Sample employee earning \$3,000 /monthly
Home mortgage or rent	\$ _____	\$ 800
Auto expenses	_____	400
Utilities	_____	225
Food and clothing	_____	450
Miscellaneous	_____	200
Total Basic Monthly Expenses	\$ _____	\$2,075

Determine Your Maximum Monthly Benefit

Multiply your hourly wage
by your normal hours worked per month (excluding overtime and bonuses) _____ X _____

Monthly Income

Multiply your monthly income by 60 percent _____ X **60%** _____

Maximum monthly benefit for which you are eligible

Subtract existing coverage including individual, group or Disability Income
and Waiver of Premium Benefit _____ - _____

Maximum monthly benefit for which you can apply _____

How much do you wish to insure? _____

Determine Your Coverage

	Monthly Benefit	Elimination Period	Benefit Period	On-the-Job Rider	Total Weekly Premium
Option 1				Y/N	
Option 2				Y/N	
Option 3				Y/N	

This is not a policy. For a complete statement of the coverages and exclusions, please see the policy contract. For more information or product availability, please contact your local independent agent.

This brochure reflects Cincinnati Life's understanding of current federal tax laws and contains information of a general nature. Since tax laws are subject to change from time to time, we suggest you seek advice from your tax adviser.



cinfin.com

The Cincinnati Insurance Companies refers to an insurer group that includes The Cincinnati Life Insurance Company.

**THE
CINCINNATI LIFE INSURANCE COMPANY**
6200 SOUTH GILMORE ROAD, FAIRFIELD, OHIO 45014-5141

(11/08)

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Bypassed -Name: Flesch Certification **Approved-Closed** 07/21/2009
Bypass Reason: N/A Advertising filing
Comments:

Review Status:
Satisfied -Name: Application **Approved-Closed** 07/21/2009
Comments:
 Form CLI-8630 advertising brochure will be used with the attached policy, CLI-508.
Attachment:
 CLI-508.pdf

Review Status:
Bypassed -Name: Health - Actuarial Justification **Approved-Closed** 07/21/2009
Bypass Reason: N/A Advertising filing
Comments:

Review Status:
Bypassed -Name: Outline of Coverage **Approved-Closed** 07/21/2009
Bypass Reason: N/A Advertising filing
Comments:

**THE
CINCINNATI LIFE INSURANCE COMPANY**

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496
(513) 870-2000

30 DAY RIGHT TO EXAMINE POLICY

We want you to be satisfied with your Insurance. Please read this Policy carefully. You may return this Policy to us or to any of our agents within 30 days after it is received by you. If you return this Policy, it will be void from the start and any premiums paid will be refunded to you.

The Cincinnati Life Insurance Company agrees to pay the insurance benefits provided by this Policy upon receipt of satisfactory written proof of loss with respect to the Insured, in accordance with the provisions of this Policy.

This Policy takes effect on the Effective Date of your Insurance shown in the Schedule of Insurance. All periods indicated in the Policy begin and end at 12:01 A.M. Standard Time at the home address of the Insured. The consideration for this Policy is your Application for Insurance and the payment of the required premiums as they become due.

THIS POLICY HAS BEEN DELIVERED IN the Issue State shown in the Schedule of Insurance and is governed by the laws of that state and to the extent applicable by the federal Employee Retirement Income Security Act of 1974, as amended (ERISA).

PLEASE READ THIS POLICY CAREFULLY: This Policy describes the benefits, provisions, exclusions, limitations, and restrictions of the Insurance that apply to you. This Policy has a Table of Contents following the Schedule of Insurance to help you find specific provisions. The terms "you" and "your" refer to the Insured named in the Schedule of Insurance. If the Insured is not the Owner, then "you" and "your" mean the Owner when referring to contract rights, payments, and notices. The Owner is named in the Application for Insurance. The terms "we," "us," and "our" refer to The Cincinnati Life Insurance Company. All other defined terms are printed with an initial capital letter.

RENEWABILITY AND OUR RIGHT TO CHANGE PREMIUMS

GUARANTEED RENEWABLE THROUGH AGE 69: You may renew this Policy at the end of each term until you are age 70. We have the right to change the premium rates for all insureds in the same Rate Class on any premium due date.

CONDITIONALLY RENEWABLE AT AGES 70 THROUGH 74: You may renew this Policy while you are actively and gainfully employed to work at least 25 hours each week. We have the right to change the premium rates for all insureds in the same Rate Class on any premium due date.

INSURANCE ENDS ON THE DATE YOU BECOME AGE 75.

The Cincinnati Life Insurance Company



Secretary



President

DISABILITY INSURANCE POLICY

Nonparticipating

INSURED: JOHN DOE

POLICY NUMBER: 12345678



THE CINCINNATI LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

INSURED: JOHN DOE

AGE: 35

RATE CLASS:
 GENDER: UNISEX
 OCCUPATIONAL CLASS: [A] [B] [C]
 PREMIUM CLASS: [SMOKER] [NON-SMOKER] [UNI-SMOKER]

POLICY NUMBER: 12345678

ISSUE STATE: XXXXX

EFFECTIVE DATE: JULY 1, 2003

MAXIMUM MONTHLY
 DISABILITY BENEFIT: [\$400 - \$5,000]

ELIMINATION PERIOD: ACCIDENT: [0, 7, 14, 30, 60, 90, 180] DAYS
 SICKNESS: [7, 14, 30, 60, 90, 180] DAYS

MAXIMUM BENEFIT PERIOD: [3, 6, 12, 24, 36, 60] MONTHS

[3 Month Maximum Benefit Period]
 [6 Month Maximum Benefit Period]
 [12 Month Maximum Benefit Period]
 [24 Month Maximum Benefit Period]

SPECIMEN

THE MAXIMUM BENEFIT PERIOD IS DETERMINED BY YOUR AGE ON THE DATE YOU BECOME DISABLED AS FOLLOWS:

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
69 OR YOUNGER	24 MONTHS
70 THROUGH 74	12 MONTHS
75 OR OLDER	NONE

[36 MONTH MAXIMUM BENEFIT PERIOD]

THE MAXIMUM BENEFIT PERIOD IS DETERMINED BY YOUR AGE ON THE DATE YOU BECOME DISABLED AS FOLLOWS:

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
62 OR YOUNGER	36 MONTHS
63 THROUGH 69	24 MONTHS
70 THROUGH 74	12 MONTHS
75 OR OLDER	NONE

[60 MONTH MAXIMUM BENEFIT PERIOD]

THE MAXIMUM BENEFIT PERIOD IS DETERMINED BY YOUR AGE ON THE DATE YOU BECOME DISABLED AS FOLLOWS:

AGE WHEN DISABILITY BEGINS

60 OR YOUNGER

61

62

63 THROUGH 69

70 THROUGH 74

75 OR OLDER

MAXIMUM BENEFIT PERIOD

60 MONTHS

48 MONTHS

36 MONTHS

24 MONTHS

12 MONTHS

NONE

SPECIMEN

**THE
CINCINNATI LIFE INSURANCE COMPANY**

SCHEDULE OF INSURANCE

PREMIUMS

PREMIUM PAYMENT PERIOD: TO AGE 75

INITIAL MODAL PREMIUM: [\$XXXX]
(INCLUDES RIDERS)

INITIAL ANNUAL PREMIUM*: [\$XXXX]
(WITHOUT RIDERS)

PREMIUM PAYMENT MODE: [MONTHLY] [QUARTERLY] [SEMI-ANNUALLY]
[ANNUALLY] [LIST BILL] [BANK-O-MATIC]

*CHANGES IN PREMIUM BASED ON CHANGES IN YOUR AGE ON AND AFTER YOUR 70TH BIRTHDAY WILL BECOME EFFECTIVE ON THE ANNIVERSARY OF THE EFFECTIVE DATE OF YOUR INSURANCE COINCIDING WITH OR NEXT FOLLOWING THE DATE OF YOUR BIRTHDAY. INSURANCE ENDS ON THE DATE YOU BECOME AGE 75.

**THE
CINCINNATI LIFE INSURANCE COMPANY**

SCHEDULE OF INSURANCE

OPTIONAL COVERAGE RIDERS

BENEFIT	BENEFIT AMOUNT	ANNUAL PREMIUM	PREMIUM EXPIRY
[ON-THE-JOB ACCIDENT RIDER]		[\$XXXX]	AT AGE 70*

*THE PREMIUM IS PAYABLE UNTIL THE ANNIVERSARY OF THE EFFECTIVE DATE OF YOUR INSURANCE COINCIDING WITH OR NEXT FOLLOWING ATTAINMENT OF THE AGE SHOWN.

SPECIMEN

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SPECIMEN

Part 1. MONTHLY DISABILITY BENEFITS

We will pay Monthly Disability Benefits to you if you provide us with satisfactory written proof that you have become Disabled prior to age 75 and while your Insurance is in force. Such Monthly Disability Benefits will be paid subject to all the terms and conditions of this Insurance. You must provide us with satisfactory written proof of loss with respect to your claim for Monthly Disability Benefits. See "How To Claim Benefits."

After you have been Disabled throughout the Elimination Period shown in the Schedule of Insurance, we will pay a Monthly Disability Benefit to you while you remain Disabled and otherwise eligible for benefits, but not beyond the end of the Maximum Benefit Period shown in the Schedule of Insurance. Your Maximum Benefit Period for each continuous period of Disability is determined by your age on the date you become Disabled.

A. Elimination Period

Elimination Period means the length of time you must be continuously Totally Disabled and under the Regular Care of a Health Care Practitioner before Monthly Disability Benefits become payable. Your Elimination Period begins on the date you become Disabled. No Monthly Disability Benefits are ever payable for the Elimination Period.

Your Elimination Period is shown in the Schedule of Insurance.

Temporary Recovery during the Elimination Period: For purposes of serving the Elimination Period, all separate periods of Disability from the same cause or causes will be added together. Such periods will then be treated as one period of continuous Disability. However, you must serve the full Elimination Period within a period of consecutive days equal to twice the length of the Elimination Period.

B. Maximum Benefit Period

Maximum Benefit Period means the longest period of time for which Monthly Disability Benefits are payable for any one period of continuous Disability. This period includes all combinations of periods of Total Disability and Partial Disability.

Your Maximum Benefit Period for Monthly Disability Benefits is shown in the Schedule of Insurance.

Temporary Recovery during the Maximum Benefit Period: For purposes of continuing Monthly Disability Benefits during the Maximum Benefit Period, any two periods of Disability from the same cause or causes will be added together. Such periods will then be treated as one period of continuous Disability if they are separated by a Period of Temporary Recovery of less than 180 days. Thus, a new Elimination Period will not be required. The Maximum Benefit Period will be the balance of the Maximum Benefit Period remaining unused before the Period of Temporary Recovery.

If a period of continuous Disability is extended by a new cause while Monthly Disability Benefits are payable, benefits will continue while you remain Disabled (subject to the terms of the Insurance), but not beyond the end of the original Maximum Benefit Period. The exclusions and limitations of the Insurance will apply to the new cause of Disability.

C. Definition of Disability

You will be considered **Disabled** if you are either Totally Disabled or Partially Disabled, as defined in this provision.

1. Total Disability

During the Elimination Period and the following twelve months of Disability, you will be considered **Totally Disabled** if you are unable, as a result of your Medical Condition, to perform the Substantial and Material Duties of your Own Occupation, you are under the Regular Care of a Health Care Practitioner, and you are not working.

After receiving benefits for twelve months, you will be considered Totally Disabled if you are unable, as a result of your Medical Condition, to perform the Substantial and Material Duties of any Reasonable Occupation, you are under the Regular Care of a Health Care Practitioner, and you are not working.

2. Partial Disability

You will be considered **Partially Disabled** if you satisfy the following conditions:

- a. You are working in your Own Occupation or a Reasonable Occupation and you are unable, as a result of your Medical Condition, to work at least 50% of the regular schedule per week that you worked prior to Total Disability or 25 hours per week, whichever is less;
- b. You received at least 30 days of Total Disability Benefits under this Policy; and
- c. You are under the Regular Care of a Health Care Practitioner.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation solely because of the loss, suspension, restriction, or surrender of your license to engage in the occupation.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation if you are able to work your normal schedule or 40 hours per week, whichever is less.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation if you are able to perform all of the Substantial and Material Duties of the occupation with a Reasonable Accommodation by an employer.

Reasonable Accommodation means changes to the work environment, equipment, or duties of the job which will enable you to perform the job and which can be made without undue hardship to the employer, as required by the federal Americans with Disabilities Act (ADA).

Own Occupation means an occupation of the same general type as the job you were performing when you became Disabled. Your Own Occupation is not limited to the specific job you were performing when you became Disabled or to work at the same location or for the same employer. If you are not working when you become Disabled, your Own Occupation means any Reasonable Occupation.

Reasonable Occupation means any occupation for which you are reasonably fitted by education, training, and experience.

Substantial and Material Duties mean the duties which are normally required for the performance of an occupation and which cannot be reasonably omitted or modified.

D. Presumptive Disability

You are considered Totally Disabled if, as a result of your Medical Condition, you suffer:

1. Complete loss of speech;
2. Complete loss of hearing in both ears;
3. Complete loss of sight in both eyes; or
4. Complete loss of the use of both hands; both feet; or one hand and one foot.

You must be under the Regular Care of a Health Care Practitioner.

We will waive the requirement that you satisfy the Elimination Period shown on the Schedule of Insurance.

E. Amount of Monthly Disability Benefit

We will pay the maximum amount of the Monthly Disability Benefit shown in the Schedule of Insurance to you for each month when you are Disabled and otherwise eligible for benefits.

F. Amount of Partial Disability Benefit

If you satisfy the definition of Partial Disability, the amount of your Monthly Disability Benefit while you are eligible for benefits will be one half (50%) of the amount of your Monthly Disability Benefit shown on the Schedule of Insurance. Benefit payments for Partial Disability will be paid for the remainder of the Maximum Benefit Period shown on the Schedule of Insurance, but not for more than six months.

G. Concurrent Disabilities

If you are Disabled from two or more causes at the same time, we will consider this to be one period of Disability. Such period will be used for purposes of determining the Elimination Period, Maximum Benefit Period and the Monthly Disability Benefit.

Part 2. EXCLUSIONS AND LIMITATIONS

A. War

You are not covered for a Disability resulting from War or any act of War.

War means declared or undclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Military Service

You are not covered for a Disability which begins while you are an active member of the armed forces of any country.

C. Excluded Medical Conditions

You are not covered for a Disability resulting from a Medical Condition that has been excluded by name or specific description on an attached Waiver which you have acknowledged in writing.

D. Preexisting Conditions

You are not covered for a Disability resulting from a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, your Insurance has been continuously in effect for at least 12 months. As no coverage is provided for a Disability resulting from a Medical Condition that has been excluded by Waiver, this provision shall not apply to an Excluded Medical Condition.

This Preexisting Condition exclusion will also apply to any increase in the amount of your Insurance as a result of a change to your Insurance. It will apply, as well, to your purchase of an optional coverage rider which becomes effective after the Effective Date of your Insurance.

Preexisting Condition means a Medical Condition or symptoms of a Medical Condition for which you have done any of the following, or for which a reasonable and prudent person would ordinarily have done any of the following, at any time during the 12-month period just before the Effective Date of your Insurance:

1. Consulted a Health Care Practitioner;
2. Received medical treatment or services; or
3. Taken insulin or prescribed drugs or medications.

For purposes of applying this Preexisting Condition exclusion to the continuation of an earlier period of Disability, any two periods of Disability resulting from the same Preexisting Condition will be added together. Such periods will then be treated as one period of continuous Disability if they are separated by a Period of Temporary Recovery of less than 180 days.

E. Self-Inflicted Injury

You are not covered for a Disability resulting from an intentionally self-inflicted injury or your attempt to commit suicide.

F. Organ Donor

You are not covered for a Disability or other loss resulting from your voluntary donation of an organ unless, on the date you become Disabled, your Insurance has been continuously in effect for at least six months. Thereafter, payment of Monthly Disability Benefits is limited to six months of Monthly Disability Benefits for each period of Disability resulting from your voluntary donation of an organ. See also the Organ Donor Benefit provision.

G. Regular Care of a Health Care Practitioner

You must be under the Regular Care of a Health Care Practitioner during your Elimination Period. No Monthly Disability Benefits will be paid for any period of Disability when you are not under the Regular Care of a Health Care Practitioner.

Regular Care means that you must see a Health Care Practitioner as often as is medically necessary to effectively manage and treat your Medical Condition in accordance with generally accepted medical standards. Regular Care also means that you must receive the most appropriate treatment and care for your Medical Condition in accordance with generally accepted medical standards.

We will waive the requirement that you are under the Regular Care of a Health Care Practitioner if we receive proof satisfactory to us that further care is no longer a benefit to you.

Health Care Practitioner means a licensed medical professional diagnosing and treating your Medical Condition within the scope of the license. The Health Care Practitioner providing Regular Care and treatment for your Medical Condition must be a Health Care Practitioner whose specialty or experience is most appropriate for your Medical Condition, in accordance with generally accepted medical standards. The Health Care Practitioner providing Regular Care and treatment

for your Medical Condition cannot be you, your parent, your grandparent, your spouse, your child, or your sibling. The Health Care Practitioner also cannot be any person related to you to the same degree by marriage, anyone living in your household, a business partner, or an employee of your employer.

H. Mental Disorder, Alcoholism, or Drug Addiction

Payment of Monthly Disability Benefits is limited to 24 months of Monthly Disability Benefits during your lifetime for Disability resulting from a Mental Disorder, alcoholism, drug addiction, chemical dependency, or the use of any hallucinogen. However, if you are confined in a Health Care Facility at the end of the 24 months, this limitation will not apply while you remain continuously confined for the treatment of your Mental Disorder, alcoholism, drug addiction, chemical dependency, or use of an hallucinogen. Benefits will not be paid beyond the Maximum Benefit Period as shown in the Schedule of Insurance for any one period of continuous Disability.

Mental Disorder means a mental, emotional, or behavioral disorder, regardless of cause, which is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders adopted by the American Psychiatric Association, or its replacement. Mental Disorders are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. Mental Disorders include, but are not limited to, mood disorders including depression and bipolar disorders, anxiety disorders, adjustment disorders, personality disorders, and schizophrenia and other psychotic disorders.

We will not apply the Mental Disorder limitation to the following Mental Disorders:

1. Dementia if it is a result of stroke, trauma, viral infection, Alzheimer's disease, or other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment;
2. Organic brain syndrome;
3. Delirium;
4. Amnesia disorders or organic delusional or hallucinogenic disorders or syndromes;
5. Permanent or progressive cognitive disorders; or
6. Permanent or progressive memory disorders.

Health Care Facility means an accredited hospital or institution licensed to provide care and treatment for your Medical Condition.

I. Normal Pregnancy

No Monthly Disability Benefits will be paid for any period of Disability from a normal pregnancy, elective abortion, or childbirth if the policy has been in effect for less than 10 months. After the policy has been in effect for 10 months, Monthly Disability Benefits will be paid as a Disability from any other sickness. We will not apply this limitation to periods of Disability resulting from a Complication of Pregnancy.

Complication of Pregnancy means a sickness which is caused by or contributed to by a pregnancy. It must be diagnosed as distinct from a normal pregnancy.

J. Felony or Violent Conduct

You are not covered for a Disability resulting from your committing or attempting to commit an assault or felony. You also are not covered for your active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot while performing your official duties.

K. In Jail

We will not pay benefits for Disability for any period when you are confined for any reason in a jail, prison, or correctional institution. This rule will only apply if you are confined for at least 30 days.

L. On-the-Job Accident

You are not covered for a Disability resulting from an On-the-Job Accident. An On-the-Job Accident is an accident that occurs while you are performing any job for pay or benefits.

M. Foreign Travel

We will not pay benefits for a Disability that occurs while you are traveling or residing outside the United States. We will pay benefits for Total Disability if, upon your return to the United States:

1. You continue to be Totally Disabled;
2. You remain in the United States; and
3. You satisfy the Elimination Period upon your return to the United States.

N. Cosmetic Surgery

You are not covered for a Disability resulting from elective cosmetic surgery.

O. Alcohol and Drugs

You are not covered for a Disability resulting, directly and independently of all other causes, from an accident that occurs while you are legally intoxicated or under the influence of drugs (legal or illegal), unless taken as prescribed by your Health Care Practitioner.

P. Aviation

You are not covered for a Disability resulting from any form of flight aviation including operating, learning to operate, serving as a crew member of, or jumping, falling, or diving from any aircraft, whether motorized or not. This does not apply if you are riding as a fare-paying passenger in a licensed or certified passenger aircraft that is provided by commercial passenger carrier on a scheduled passenger air service regularly offered over an established passenger route.

Q. Partial Disability

Payment of Monthly Disability Benefits while you are Partially Disabled is limited to six months during any one period of continuous Disability.

Part 3. OTHER BENEFITS AND PROVISIONS AFFECTING BENEFITS

A. Organ Donor Benefit

If you are an organ donor, we will pay Monthly Disability Benefits for up to six months for a period of Disability resulting from your voluntary donation of an organ, provided that your Insurance has been in effect for at least six months before you become Disabled. See also the Organ Donor limitation.

B. Return to Work Services

We may provide return to work services and additional financial incentives to help you return to work to the extent of your ability. We will review your claim for Monthly Disability Benefits to determine if return to work services might help you return to gainful employment. If we determine that return to work services are appropriate, we may provide, at our sole discretion, one or more of the following services:

1. Evaluation of adaptive equipment to allow you to work in your Own Occupation or a Reasonable Occupation;
2. Evaluation of possible workplace modifications which might allow you to return to work in your Own Occupation or a Reasonable Occupation;
3. Vocational evaluation to determine how your Disability may impact your ability to work in your Own Occupation or a Reasonable Occupation;
4. Job placement services, including resume preparation services and training in job seeking skills;
5. Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance your ability to work;

6. Payment of a medical or prosthesis expense, education expense, or moving expense to make it possible for you to work and for which no other reimbursement is available to you;
7. Payment of Reasonable Accommodation expenses to allow you to work in your Own Occupation or a Reasonable Occupation; or
8. Payment of training or retraining expenses to enable you to return to work in a Reasonable Occupation.

C. Waiver of Premium

After the first 90 days of a continuous period of Disability, your Insurance in effect when you became Disabled will be continued without further payment of premiums while you remain continuously Disabled. If you qualify for this benefit, any premiums due and paid for the first 90 days of the continuous period of Disability will be refunded after you have been continuously Disabled for 90 days. This benefit is subject to the Exclusions and Limitations of this Policy. Such benefit will end on the date Monthly Disability Benefits end (even if you remain continuously Disabled beyond that date). When you are no longer eligible for this benefit, you may continue your Insurance in force by resuming payment of the premiums as they become due.

D. Benefits After Insurance Ends or is Changed

Your right to receive benefits under this Insurance for a period of continuous Disability which begins while your Insurance is in effect will not be affected by the termination or amendment of your Insurance for any reason after the start of the period of continuous Disability.

Part 4. APPLICATIONS, TERMINATION, PREMIUMS, AND REINSTATEMENT

A. Becoming Insured

You must apply for Insurance. Your Insurance will become effective on the date shown in the Schedule of Insurance.

Application for Insurance means a form completed and signed by you, together with your signed authorization for us to obtain information about your health, finances, and other insurance coverage.

B. Cancellation by the Insured

You may cancel this Policy at any time by delivering or mailing us a written notice. Cancellation will be effective upon our receipt of the notice or on the later date specified in the notice. We will promptly return the pro rata unearned portion of any premium paid. We will compute the refund from the later of the date we receive your notice of cancellation or the date specified in

the notice. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

C. When Insurance Ends

Your Insurance will end automatically on the earliest of the following dates:

1. The date you become a full-time member of the armed forces of any country;
2. At 12:01 A.M. on the date following the end of the 31-day Grace Period if you fail to pay the required premium for your Insurance by the end of the 31-day Grace Period;
3. The date on or after your 70th birthday when you cease to be regularly scheduled to work at least 25 hours each week for an employer or in self-employment; or
4. The date you become age 75.

D. Premiums

Premiums are due on the first day of the period for which they are payable. Premiums are payable for as long as your Insurance is in effect, but not beyond the end of the Premium Payment Period shown in the Schedule of Insurance.

If the premium charges for your Insurance are billed directly to you, the premium statement will be mailed to you. It will be mailed to the address shown on your Application for Insurance or to your last known address on the date of the mailing.

Premium Refund at Death: If you die while your Insurance is in force and we are notified of your death, we will refund the pro rata, unearned portion of any premium paid. No interest will be payable on any refund of premium. We will compute the refund from the end of the Policy month during which you died. The premium refund will be paid to your estate.

The amount of the premium for your Insurance is determined by your age and Rate Class on the Effective Date of your Insurance, as shown in the Schedule of Insurance.

Your Initial Annual Premium and Premium Payment Mode are shown in the Schedule of Insurance. We have the right to change the premium rates for all insureds in the same rate class on any premium due date. We will give you at least 60 days prior written notice of a change in your premium rates. No increase to your premium rate will become effective before your Insurance has been in effect for one year.

E. Grace Period

There is a 31-day Grace Period for each premium due after the first premium. If a premium is not

paid on or before the premium due date, the premium may be paid during the following 31-day Grace Period. Your Insurance will remain in force during the Grace Period. You will be liable to us for the payment of the premium for that period. If the required premium for your Insurance is not paid during the Grace Period, your Insurance will terminate automatically at 12:01 A.M. on the date following the end of the Grace Period.

F. Reinstatement

If your Insurance ends because the required premium was not paid during the Grace Period, your Insurance will be reinstated if we accept your premium payment after the end of the Grace Period without requiring an application for reinstatement. If we require an application for reinstatement and issue a Conditional Receipt for the premium tendered, your Insurance will be reinstated if we do not give you written notice of our approval or disapproval of your application within 45 days. Such reinstatement will then be effective when we approve your application for reinstatement or on the 45th day after the date of your application for reinstatement. You must apply for reinstatement of your Insurance within 180 days after the date your Insurance ends. The reinstated Insurance will only cover losses resulting from an accidental bodily injury sustained after the date of reinstatement and losses resulting from a sickness beginning more than ten days after the date of reinstatement. In all other respects our rights under the Policy will be the same as on the last day of the Grace Period, except as reflected in any Policy modification issued in connection with the reinstatement.

G. Your Right to Reinstate Coverage Following Active Military Service

Your Insurance will end if you become an active full-time member of the armed forces of any country. Active military service does not include periodic training that lasts less than three months at a time. Active military service does include any period when you are called to active duty. You must give us written notice that you have become an active full-time member of the armed forces.

If your military service ends within 60 months after your Insurance ended because of your military service, you will have the right to become insured again within 90 days after your military service ends. No evidence of insurability will be required. You must notify us of your desire to resume your Insurance coverage and pay the required premium within 90 days after your military service ends.

The Preexisting Condition exclusion will apply to your new period of Insurance coverage.

Part 5. HOW TO CLAIM BENEFITS

A. Payment of Benefits; Time of Payment

All benefits will be paid to you unless you send us a written request designating another person to receive benefits payable under this Policy. Any benefits remaining unpaid at your death will be paid to your estate.

All benefits payable under your Insurance will be paid within 60 days after we receive satisfactory written proof of loss in connection with the claim for benefits. All accrued Monthly Disability Benefits will be paid at least once a month during the continuance of the period for which the benefits are payable. Any benefits remaining unpaid at the end of that period will be paid as soon as possible after the receipt of satisfactory written proof of loss in connection with the claim for benefits. After the Elimination Period, for any period of Disability of less than one month, we will pay 1/30 of the Monthly Disability Benefit for each day you are Disabled.

B. Notice of Claim and Time Limits for Filing a Claim

We encourage you to notify us of your claim as soon as possible so that a decision on your claim can be made. You should send us written notice of your claim within 31 days after the date you become Disabled or have another loss, or as soon as reasonably possible. If you have a cognitive impairment, your primary care giver or conservator can provide us with notice of your claim.

You must claim benefits by providing satisfactory written proof of loss to support your claim within 90 days after the date that benefits become payable or as soon thereafter as reasonably possible. In any case, you must claim benefits within one year after the end of that 90-day period. If your claim is not filed within these time limits, then your claim will be denied and no benefits will be paid. These limits will not apply during any period when you lacked the legal capacity to file a claim. If you have a cognitive impairment, your primary care giver or conservator can provide us with proof of loss to support your claim.

C. Claim Forms

Your claim for benefits should be submitted on our forms. We will send claim forms to you after we receive notice of your claim.

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If you do not receive the claim forms within 15 days of the date you give us notice of your claim, you may submit your claim to us in a letter stating the occurrence, character, and extent of your Medical Condition or the event for which the claim is made.

D. Proof of Loss

No benefits will be paid unless you provide us with satisfactory written proof of loss at your expense. Once your claim is approved, no benefits will be continued beyond the end of the period for which you have provided us with satisfactory written proof of loss at your expense.

To provide us with satisfactory written proof of loss, you must provide us with certain documents at your expense. We may agree to waive written documentation of information we receive in another way, such as information received electronically or by telephone. The following documents must be provided:

1. A completed claim form signed by you;

2. A completed claim statement signed by your employer;
3. A completed claim statement signed by your Health Care Practitioner;
4. Your written authorization for us to obtain the records and information (including tax returns) we need to determine your eligibility for benefits, including information from Health Care Practitioners, hospitals, employers, other insurance carriers, and information bureaus; and
5. Any other documents we may reasonably require to evaluate your claim.

If you have a cognitive impairment, your primary care giver or conservator can provide us with proof of loss to support your claim.

We will require you to submit additional documentation of your claim at your expense at reasonable intervals while you are claiming benefits.

Proof of Disability: Proof of ongoing Disability must be furnished monthly, unless we send you written notification that proof is required less frequently. The required proof must include monthly claim progress reports completed by you and your Health Care Practitioner.

E. Investigation of Your Claim and Independent Examination of You

We have the right at any time to investigate your claim. We have the right to require that you meet with one of our staff or a person we choose for a personal interview. We will meet with you at reasonable times and not more often than we need to in order to make a decision on your claim. We have the right to review records from your work to help us make a decision on your claim. We may look at your employment or payroll records, and financial statements from a business entity where you work or did work. We may also look at other business or professional records that show your work earnings and what you are able to do. We have the right to receive a copy of these records. We also have the right to look at these records during regular business hours at the business location where the records are maintained.

We have the right to have you examined by one or more Health Care Practitioners or work rehabilitation specialists of our choice while you are claiming benefits for Disability. If we require you to see a Health Care Practitioner or other person of our choice, the visit and all tests will be at our expense. The testing we require may include a physical or mental exam, and a review of your functional capacity. It may also include all related tests that we need to conduct a full review of your claim.

We have the right to defer or suspend benefits if you fail to show up for an examination we schedule for you or if you fail to cooperate in good faith with the person who does the testing. In such a case, benefits may be paid later or start again if the required testing is done within a reasonable time and we conclude that benefits are due to you.

F. Your Duty to Cooperate with Us; Our Duty to Communicate with You

You must cooperate with us as we evaluate your claim for benefits. If you file a claim for benefits with us, a contact person will be assigned to coordinate the evaluation of your claim. The contact person will answer any questions you may have. If we are unable to approve or deny your claim for benefits within 15 days of receipt of satisfactory proof of loss, we will give you written notice that we need more time to evaluate your claim. The written notice will include the reason for the delay. The written notice will also tell you if there is any additional information or documentation you must submit to obtain benefits.

G. Notice of Decision on Your Claim; Your Right to Review

We will give you a written notice of our decision on your claim within 15 days after we receive the required proof of loss on your claim or, if we notify you that we need more time to evaluate your claim, within 30 days after we receive your proof of loss. If we deny all or any part of your claim, we will give you the following information in writing:

1. We will give you the reasons for our denial of all or any part of your claim;
2. We will refer to the wording of your Insurance which is the basis for the denial of all or any part of your claim; and
3. We will describe the additional information, documents, or proof of loss you must submit to obtain benefits and explain why we need more information in order to pay your claim.

You have a right to a review of any denial by us of all or any part of your claim. To obtain a review, you should send a written request for review to us within 180 days after you receive notice of the denial. No special form is required. As a part of your request for a review, you may submit issues and comments in writing. You may also give us more information, documents, and proof of loss in support of your claim. If you have a cognitive impairment, your primary care giver or conservator can request a review of your claim. You may review pertinent documents related to your request for review. We will review your claim promptly after receiving your request for review. You will receive written notice of our decision within 45 days after your written request for review is received.

H. Time Limits on Legal Actions

You cannot start any legal action against us for benefits until at least 60 days after we have received written proof of loss in support of your claim. You also cannot start any legal action against us without first exercising your right to request that we review our denial of all or any part of your claim or more than three years after the time limit for giving us proof of loss in support of your claim has expired.

I. Misstatement of Age

If your age has been misstated, any benefits payable under your Insurance will be adjusted to equal the benefits the premiums paid would have purchased at the correct age. Your rate class will be the rate class based on the correct age.

J. Assignment

You may assign the benefits payable under your Insurance. We are not responsible for the validity of any assignment. No assignment is binding on us until a copy of the assignment is received by us.

Part 6. INCONTESTABLE CLAUSE

Any statement you make to obtain Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider is a representation and not a warranty. We will rely on the statements you make in your application in order to approve your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider. You are responsible for verifying the accuracy of each statement you make to obtain Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider, to the best of your knowledge and belief.

No misrepresentation by you will be used to reduce or deny your claim for loss incurred or Disability commencing while insured or to deny the validity of your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider unless all of the following are true:

1. We would not have approved your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider as issued if we had known the truth;
2. Your misrepresentation is contained in a written document signed by you; and
3. You have been given a copy of the written document containing your misrepresentation.

After your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider has been in effect for two years during your lifetime, we will not use a misrepresentation by you, unless it was a fraudulent misrepresentation. A fraudulent misrepresentation may be used to reduce or deny your claim for loss incurred or Disability commencing after the expiration of the two-year period. It may also be used to deny the validity of your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider.

Part 7. THE CONTRACT

A. Entire Contract; Changes

The entire contract between you and us consists of this Policy, the Application for Insurance, any

supplemental applications, and any attached papers prepared by us which state that they become a part of the Policy.

The Policy may be changed in whole or in part, subject to the following rules: No change in the Policy which reduces or eliminates coverage will be valid unless it is requested in writing or accepted in writing by you and approved by one of our executive officers. No change to this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to you for attachment to this Policy.

No agent has the authority to change the Insurance of any Insured.

B. Conformity with State Statutes

Any provision of this Policy which is in conflict with the laws of the Issue State in effect on the Effective Date of your Insurance is amended to conform to the minimum requirements of the laws of the Issue State in effect on that date.

Part 8. GENERAL DEFINITIONS AND INDEX OF DEFINED TERMS

The defined terms used in this Policy are defined here or in another part of this Policy. The Index of Defined Terms tells you where to find each definition. Except for "you," "your," "we," "us," and "our," all defined terms are printed with an initial capital letter whenever they are used in this Policy. All defined terms have the same meaning wherever they are used in this Policy.

Insurance means the coverage provided for you under this Policy.

Monthly Disability Benefit means the benefits payable under this Insurance because of your Disability.

Medical Condition means your sickness, accidental bodily injury, pregnancy, Mental Disorder, or cognitive impairment.

Period of Temporary Recovery means any time following a period of Disability when we do not consider you Disabled.

We, Us, and Our. See cover page of Policy.

You and Your. See cover page of Policy.

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**THE
CINCINNATI LIFE INSURANCE COMPANY**

**P.O. BOX 145496, CINCINNATI, OHIO 45250-5496
(513) 870-2000**

DISABILITY INSURANCE POLICY
Nonparticipating

Form CLI-508 (5/04)