

SERFF Tracking Number: HUMA-126757016 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 46448
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: 1695 Group Trust LTD STD
Project Name/Number: /

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: 1695 Group Trust LTD STD

TOI: H11G Group Health - Disability Income

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num:

Long Term

Filing Type: Form

SERFF Tr Num: HUMA-126757016 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46448

Author: Donna Faulkenberry

Date Submitted: 08/10/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 10/25/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: 09/13/2010

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Informational

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/25/2010

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Trust

Explanation for Other Group Market Type:

State Status Changed: 10/25/2010

Created By: Donna Faulkenberry

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Donna Faulkenberry

Filing Description:

RE: Kanawha Insurance Company

Out-of-State Group

Group Long-Term and Short-Term Disability Form No. 1695

Group Long-Term Disability Form No. 1696

Group Short-Term Disability Form No. 1697

Group Enrollment Form No. RI-01493-WB 12/09

Group Master Application Form No. RI-01698-WB 12/10

Group Evidence of Insurability Form No. GN-01490-WB 12/09

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Dear Commissioner Bradford:

Kanawha Insurance Company is submitting the above captioned out-of-state group long- and short-term disability forms for the Department's information. The policy form and certificates are being issued through a trust situated in the State of Rhode Island. The Rhode Island Department of Insurance approved the forms on August 3, 2010. A copy of the SERFF electronic filing disposition showing the Rhode Island approval is enclosed for your reference.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the Master Application and Enrollment Form may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records.

We trust that this filing satisfies the filing requirements for out-of-state groups. If you should have any questions, please contact me at 1-800-635-4252 Ext 5424. My email address is dfaulkenberry8@humana.com.

Sincerely,

Donna Faulkenberry

Company and Contact

Filing Contact Information

Donna Faulkenberry, Compliance Specialist dfaulkenberry8@humana.com
210 South White Street 803-283-5445 [Phone]
Lancaster, SC 29721

Filing Company Information

Kanawha Insurance Company CoCode: 65110 State of Domicile: South Carolina
210 South White Street Group Code: 119 Company Type:
Lancaster, SC 29721 Group Name: State ID Number:
(800) 635-4252 ext. [Phone] FEIN Number: 57-0380426

Filing Fees

Fee Required? Yes
Fee Amount: \$300.00

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Retaliatory? No
Fee Explanation: 6 forms at \$50.00 per form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	\$300.00	08/10/2010	38650431

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/25/2010	10/25/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Category of Group Accident and Health	Note To Reviewer	Donna Faulkenberry	10/15/2010	10/15/2010
Category of Group Accident and Health	Note To Filer	Rosalind Minor	08/20/2010	08/20/2010
Rhode Island Trust	Note To Reviewer	Donna Faulkenberry	08/16/2010	08/16/2010
Rhode Island Trust	Note To Filer	Rosalind Minor	08/13/2010	08/13/2010

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Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	RI Approval	Approved-Closed	Yes
Form	LTD/STD Trust Policy	Approved-Closed	Yes
Form	LTD Trust Certificate	Approved-Closed	Yes
Form	STD Trust Certificate	Approved-Closed	Yes
Form	Evidence of Insurability	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes

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Note To Reviewer

Created By:

Donna Faulkenberry on 10/15/2010 03:16 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/25/2010 01:58 PM

Subject:

Category of Group Accident and Health

Comments:

The LTD/STD policy is issued to a trust situated in the State of Rhode Island. We wish to provide coverage under the policy to employers located in the State of Arkansas and are seeking approval under 23-86-106(5).

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Note To Filer

Created By:

Rosalind Minor on 08/20/2010 09:16 AM

Last Edited By:

Rosalind Minor

Submitted On:

10/25/2010 01:58 PM

Subject:

Category of Group Accident and Health

Comments:

Thank you for the copy of the Trust Agreement and advising that the category is group accident & health.

I need further explanation of the category. On what bases will the policy be issued, i.e., ACA 23-86-106(1)(A), (3)(A), (4) or (5)?

Thank you for your cooperation.

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Note To Reviewer

Created By:

Donna Faulkenberry on 08/16/2010 12:46 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/25/2010 01:58 PM

Subject:

Rhode Island Trust

Comments:

This is not a MET and is filed under the category of group accident and health. A copy of the trust agreement is attached.

Thank you,

Donna Faulkenberry

1-800-635-4252 x5424

TRUST AGREEMENT

This TRUST AGREEMENT is made and entered into as of the 29th day of January, 2010, by and between Kanawha Insurance Company, a South Carolina corporation (“Kanawha”) as Settlor (the “Settlor”) and as Trust Administrator (the “Trust Administrator”) on behalf of all participating Members as defined in paragraph 4 hereof, and The Bank of New York Mellon, a banking corporation organized and existing under the laws of the State of New York, having offices located in Rhode Island, as Trustee (the “Trustee”.)

WITNESSETH:

WHEREAS, the purpose of this Trust Agreement is to establish a trust to be known as the Kanawha Insurance Disability Trust (the “Trust”) to provide group insurance programs for the benefit of participating members as defined in paragraph 4 hereof; and

WHEREAS, the Trustee is willing to assume the responsibilities set forth in this Trust Agreement; and

WHEREAS, the Settlor agrees to establish the Trust; and

NOW, THEREFORE, in consideration of the foregoing and of the agreements hereinafter provided, and for good and valuable consideration the receipt of which is hereby mutually acknowledged, it is hereby agreed as follows:

1. The Settlor hereby creates and establishes the Trust and appoints the Trustee as trustee of the Trust, and the Trustee hereby accepts such appointment, to have all rights, powers, and duties set forth herein and in accordance with the applicable law with respect to accomplishing the limited purposes of the Trust.
2. The Settlor will arrange for issuance and delivery to the Trustee of and the Trustee will accept and hold as Trustee in the Trust, group insurance policies providing life, accidental death and dismemberment, health or other insurance, as the Settlor may determine and instruct Trustee in writing. These insurance policies will be the sole assets of the Trust. They will provide insurance coverage for employers, individuals or employees in an eligible industry who desire to participate and become parties to this Trust Agreement subsequent to its execution (“Participating Members”) and for eligible dependents of those Participating Members. References in this Trust Agreement to coverage for Participating Members shall be construed to include coverage for dependents unless the context otherwise requires.

3. The Settlor will direct the Trustee in writing with respect to the exercise of any right, privilege or duty of the Trustee as applicant and as policyholder under the terms of any insurance policy applied for, accepted and held by the Trustee pursuant to Paragraph 2 hereof. The Trustee will, upon the written direction of the Settlor, release the insurance policies to such person or persons designated in such direction.
4. A Participating Member under this Trust Agreement is any employer, employee or individual who (a) agrees in writing with the Settlor to abide by the terms of the insurance policy which is issued to the Trustee covering such employer, employee or individual, and (b) is approved as having met all applicable underwriting requirements for insurance coverage.
5. The benefits provided to any person through the Trust will be those benefits payable under any insurance policy which covers such person and which is issued to the Trustee. The duty of the Trustee in connection with each such policy or the benefits payable under it will be limited solely to the safekeeping of the policy. The Trustee will not be liable for the form, genuineness, validity, sufficiency or effects of the insurance policies, nor for any act of any person or persons that may adversely affect the insurance policies or which may render the policies null and void. The Trustee as holder of the policies shall assume no discretionary duties or responsibilities whatsoever, and the Trustee shall have no authority to determine what policies are held in the Trust or the terms of such policies or control over management or disposition of such policies. The Trustee will not be liable for any delay in any payment under the insurance policies resulting from any provision therein or otherwise, nor should the policies lapse or otherwise will the Trustee be liable. Except as provided in Section 2 hereof, the Trustee will have no responsibility in connection with the execution or approval of any document (including any application) with respect to participation in the insurance policies. The Trustee shall not be required to undertake or defend any litigation which may arise by reason of the existence of the insurance policies or this Trust Agreement unless first satisfactorily indemnified therefor in respect of all costs, expense, and liability related thereto. Neither the Trust nor the Trustee will be responsible or liable in any way for the payment or collection of premiums or benefits. Benefits will be payable directly from the insurer to or on behalf of any covered person.
6. A Participating Member will pay directly to the insurer or its authorized representative premiums as set forth in the policy. The Trustee will not collect, accept or hold any premium payment whatsoever. Any failure by a Participating Member to pay a premium will result in full or partial termination, as the case may be, of any right, if any, of such employer's

employees to participate in Trust benefits consisting of coverage under the terms of the policy, except for such benefits as may continue to be provided under the policy even though coverage has terminated.

7. The Trustee will be liable only for its own gross negligence, willful misconduct or lack of good faith in the performance of its duties under this Trust Agreement and will have no liability for or responsibility with respect to the duties of the Settlor hereunder or of the Trust Administrator. In no event shall the Trustee be liable for any indirect, consequential, punitive or special damages. The Trustee is authorized to follow and rely upon all instructions given by officers named in incumbency certificates furnished to the Trustee from time to time by the Settlor or the Trust Administrator, and by attorneys-in-fact acting under written authority furnished to the Trustee by the Settlor or the Trust Administrator, including, without limitation, instructions given by letter, facsimile transmission, or electronic media, if the Trustee believes such instructions to be genuine and to have been signed, sent or presented by the proper party or parties. The Trustee shall not incur any liability to anyone resulting from actions taken by the Trustee in reliance in good faith on such instructions. The Trustee shall not incur any liability in executing instructions (i) from any attorney-in-fact prior to receipt by it of notice of the revocation of the written authority of the attorney-in-fact or (ii) from any officer of the Settlor or the Trust Administrator named in an incumbency certificate delivered hereunder prior to receipt by it of a more current certificate. The Settlor and the Trust Administrator each acknowledges and agrees that it is fully informed of the protections and risks associated with the various methods of transmitting instructions to the Trustee, and that there may be more secure methods of transmitting instructions than the method selected by the sender. The Settlor and the Trust Administrator each agrees that the security procedures, if any, to be followed in connection with a transmission of instructions provide to it a commercially reasonable degree of protection in light of its particular needs and circumstances.
8. The Settlor will pay to the Trustee a reasonable fee for the services that the Trustee renders under this Trust Agreement and the Trustee shall be reimbursed by the Settlor upon demand for all expenses, disbursements and advances incurred or made in connection with this Trust Agreement. The amount of the fee will be mutually agreed upon from time to time by the Trustee and the Settlor. The Trustee may employ legal counsel of its own choosing and shall be reimbursed for the fees incurred on behalf of the Trust (and the Trustee shall not incur any liability in acting in good faith in accordance with any advice from such counsel).

9. Settlor shall pay any taxes and shall file any required tax returns, informational returns or governmental reports arising out of the operation of the Trust.
10. The Trustee may be removed by the Settlor at any time upon 60 days written notice to the Trustee. The Trustee may resign at any time upon 60 days written notice to the Settlor. Upon removal or resignation of the Trustee, the Settlor will designate a successor herein upon the Trustee. Upon the designation by the Settlor of a successor Trustee, the Trustee, by appropriate instruments provided to it by the Settlor, will assign and transfer to the successor Trustee all of the insurance policies that comprise the assets of the Trust, as well as all records, books and documents held by the Trustee for, or incident to, fulfillment of the Trustee's obligation under this Trust Agreement. Any successor Trustee appointed by the Settlor shall execute and deliver to the Settlor an instrument by which the successor Trustee accepts the Trust created by this Trust Agreement. Should the trust be terminated or should the Trustee resign or be removed, and no successor trustee has been appointed within 30 days of the resignation or removal, the Trustee will immediately return the Insurance policies to the Settlor and will execute notifications or other documents and instruments provided to it relating to the transfer of the insurance policies, and upon such return and transfer, the Trustee will no longer be the policyholder thereunder.
11. The Settlor reserves the right at the time and from time to time by an instrument executed, acknowledged and filed with the Trustee to alter amend, or revoke this Trust Agreement in whole or in part; provided, however, that no such alteration, amendment or revocation which in the opinion of the Trustee affects its rights or duties may be made without its consent. Neither the Trustee nor the Settlor has the authority to incur any expense or obligation on the part of the other or on the part of a Participating Member.
11. This Trust is established in the State of Rhode Island and all questions pertaining to its validity, construction and administration shall be determined in accordance with the applicable laws of that jurisdiction. Each of the parties hereto hereby submits to the personal jurisdiction of and each agrees that all proceedings relating hereto shall be brought in courts located within the State of New York or elsewhere as the Trustee may select. Each of the parties hereby waives the right to trial by jury in any such proceedings.
12. If any provision of this Trust Agreement proves to be or is held by any judicial authority of competent jurisdiction to be invalid, such invalid provision may be deemed to be null and void and no party thereof, buy

invalidation by any provision will not otherwise impair or effect this Trust Agreement or any of its other provisions or items.

13. This Trust Agreement shall have a term of twenty (20) years from the date it is made and entered into, unless it is terminated earlier according to the provisions of Section 9 herein or renewed or extended for a mutually agreed upon term.
14. If at any time Trustee is served with any judicial or administrative order, judgment, decree, writ or other form of judicial or administrative process which in any way affects the deposited policies (including but not limited to order of attachment of garnishment or other forms of levies or injunctions or stays relating to the transfer of the deposited policies), subject to the terms and provisions of this Trust Agreement and the Indemnification Agreement, dated the date hereof, between the parties hereto, the parties agree that they and their respective employees, officers and directors shall fully cooperate with the other party at all times during the pendency of the claim or lawsuit, including without limitation, providing the other party with all available information with respect thereto.
15. The Settlor has appointed Kanawha as Trust Administrator to administer the group insurance program of which the Trust is a part and Kanawha hereby accepts such appointment. The Trustee shall not be responsible in any way for the selection, supervision or continued retention of the Trust Administrator, such selection, supervision and retention being entirely the responsibility of the Settlor.
16. The Trust Administrator shall, in general, act as a liaison among the Trustee, Settlor, the company or companies providing said group insurance and the agent of record for such policy or policies and shall, on Kanawha's behalf, perform such ministerial acts with respect to the Trust as Kanawha shall from time to time require including by way of example and not by way of limitation, the following:
 - a. The billing and receipt of contributions, if applicable, from Participating Members under the Trust for payment to the Trust Administrator in the manner determined by the Trust Administrator;
 - b. The maintenance of eligibility records and any records pertinent to the Trust in a form satisfactory to Settlor and the insurance company or companies providing said group insurance, which records shall be kept available by the Trust Administrator for inspection during regular business hours by Settlor and said insurance company or companies or their respective authorized representative;

- c. The promotion of the Trust, provided that the Trust Administrator shall not be required to perform promotional services which shall be discretionary with the Trust Administrator, and provided further that should such services be furnished, the Trust Administrator shall not permit the publication of any promotional material bearing the name of the Trustee or Settlor without first having obtained the written permission of the Trustee or Settlor to do so;
 - d. The distribution to Participating Members, their eligible employees, and their eligible dependents of group insurance certificates, if and when and as often as required.
17. The responsibilities of the parties identified in this Trust Agreement and the acts performed by the respective parties to fulfill their responsibilities shall not establish any party as fiduciary under the Employee Retirement Income Security Act of 1974, as amended (ERISA) or and ERISA Plan Administrator as both of the terms are defined under ERISA. The Plan Administrator of each plan is the respective participating employer. In no event shall Settlor in any of its capacities be the Plan Administrator. The term "Trust Administrator" as used in this Agreement only establishes the identity of the party with certain obligations to the other named parties as explained herein.
18. The Trustee shall not incur any liability for not performing any act or fulfilling any duty, obligation or responsibility hereunder by reason of any occurrence beyond the control of the Trustee (including but not limited to any act or provision of any present or future law or regulation or governmental authority, any act of God or war or terrorism, accidents, labor disputes, loss or malfunction of utilities or computer software or hardware.)
19. It is agreed that the Trustee shall be entitled to scan, image or otherwise convert the insurance policies held in the Trust, and any riders, endorsements, amendments or other documents related to the insurance policies as may be supplied to the Trustee, into an electronic format of any nature, and it is agreed that a copy of an insurance policy, or any rider, endorsement, amendment or other document related to such insurance policy, produced from such electronic format shall be deemed to be and shall be accepted as an original for all purposes of this Trust Agreement, and the Trustee shall have no liability for the loss or destruction of any original insurance policy or related document to the extent that such a copy may be produced and provided hereunder.

20. Unless otherwise provided in this Trust Agreement, all notices, directions, requests, demands, acknowledgments and other communications required or permitted to be given or made under the terms hereof shall be in writing and shall be deemed to have been duly given or made (a)(i) when delivered personally, (ii) when made or given by telecopier, facsimile or electronic media, or (iii) in the case of mail delivery, upon the expiration of three days after any such notice, direction, request, demand, acknowledgment or other communication shall have been deposited in the United States mail for transmission by first class mail, postage prepaid, or upon receipt thereof, whichever shall first occur and (b) when addressed as follows:

If to the Settlor:

Kanawha Insurance Company
210 South White Street
Lancaster, South Carolina 29720
Attention: Specialty Benefits

If to the Trust Administrator:

Kanawha Insurance Company
210 South White Street
Lancaster, South Carolina 29720
Attention: Specialty Benefits

If to the Trustee:

The Bank of New York
101 Barclay Street, 7W
New York, New York 10286
Attention: Corporate Trust, Dealing and Trading
Facsimile: (212) 815-2940

Each party may from time to time designate a different address for notices, directions, requests, demands, acknowledgments and other communications by giving written notice of such change to the other parties.

19. This Trust Agreement may be executed by each of the parties hereto in any number of counterparts, each of which counterpart, when so executed and delivered, shall be deemed to be an original and all such counterparts shall together constitute one and the same agreement.

20. In order to comply with its duties under the USA Patriot Act, the Trustee may obtain and verify certain information and documentation from the Settlor and the Trust Administrator, including, but not limited to, each such party's name, address and other identifying information.

IN WITNESS WHEREOF the parties have hereto set their hand and seal as of the date first above written.

KANAWHA INSURANCE COMPANY

**As SETTLOR and
TRUST ADMINISTRATOR**

BY: _____

NAME: _____

TITLE: _____

THE BANK OF NEW YORK MELLON

As TRUSTEE

BY: Paul Zhang

NAME: PAUL ZHANG

TITLE: Senior Associate

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Note To Filer

Created By:

Rosalind Minor on 08/13/2010 09:25 AM

Last Edited By:

Rosalind Minor

Submitted On:

10/25/2010 01:58 PM

Subject:

Rhode Island Trust

Comments:

Please verify whether the trust is a multiple employer trust. If it is, the trust needs to be registered with our License Division. Refer to our law at ACA 23-92-101 et al. The forms to register the trust may be reviewed on our License Division website at <http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TUST, MET, MEWA for registration instructions and forms.

If this is not a MET, please attach a copy of the trust agreement and inform as to what category under our Group law are you filing under? Refer to ACA 23-86-106.

We appreciate your cooperation in this matter.

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/25/2010	1695	Policy/Cont ract/Fratern al Certificate	LTD/STD Trust	Initial		40.000	1695 LTD_STD 2-9 Trust Policy.pdf
Approved- Closed 10/25/2010	1696	Certificate	LTD Trust Certificate	Initial		41.000	1696 2-9 Trust LTD Cert.pdf
Approved- Closed 10/25/2010	1697	Certificate	STD Trust Certificate	Initial		44.000	1697 2-9 Trust STD Certificate.pdf
Approved- Closed 10/25/2010	GN-01490- WB 12/09	Application/ Enrollment Form	Evidence of Insurability	Initial		49.000	GN-01490- WB 12-09 Brackets - EOI form - JOHN DOE.pdf
Approved- Closed 10/25/2010	RI-01493- WB 12/09	Application/ Enrollment Form	Enrollment Form	Initial		54.000	RI-01493-WB 12-09 Brackets JOHN DOE.pdf
Approved- Closed 10/25/2010	RI-01698- WB 2/10	Application/ Enrollment Form	Master Application Enrollment Form	Initial		45.000	RI-01698-WB 2-10 JOHN DOE.pdf

KANAWHA INSURANCE COMPANY
[210 SOUTH WHITE STREET, POST OFFICE BOX 610]
[LANCASTER, SOUTH CAROLINA 29721-0610]
TELEPHONE [1-800-635-4252]

(A stock insurance company, herein called The Company)
will pay benefits according to the terms and conditions of The Policy.

[GROUP SHORT TERM DISABILITY INSURANCE] [AND] [GROUP LONG TERM DISABILITY INSURANCE]

NON-PARTICIPATING

Name of Policyholder: [Kanawha Insurance Disability Trust]

Policy Number:
[XXXXXX]

Effective Date:
[January 1, 2004]

Place of Delivery:
[ANY STATE]

Anniversary Dates:
[January 1 of each year beginning in 2005]

Premium Due Dates:
[Monthly, on the first day of each policy month]

The Policy is a legal contract between Kanawha Insurance Company ("Company") and the Policyholder. All the provisions on this page and the following are part of the Policy.

The insurance offered by the Company is shown on the Application for the Policy. Insurance selected by the Policyholder and issued by the Company is shown on the Schedule. Insurance on Covered Person is shown in their Certificates.

The Policy may be renewed on each Policy Renewal Date by agreement between the Company and the Policyholder. Any change in the terms will be shown on an amendment or amended Schedule.

The Policy is non-participating. This means that it will not share in the Company's profits or surplus earnings and the Company will pay no dividends on it.

The Policy is issued in and governed by the laws of [State].

The Policy application may have been captured electronically or on paper. Please carefully review answers to questions on the Application to make sure they are answered correctly. If an error exists, please notify Us immediately.

Signed for The Company



[
[Joan O. Lenahan]
[Vice President and Corporate Secretary]



] [
[R. Dale Vaughan]
[President]

[TEN DAY RIGHT TO EXAMINE POLICY

The Company urges you to examine this policy closely. If you are not satisfied with it, you may send it back to The Company for any reason within 10 days after the date you receive it. If so returned, your insurance will be canceled, and any premium paid will be refunded in full.]

Countersigned by.....
[Licensed Resident Agent or] Registrar

Table of Contents

[Schedule of Insurance-Eligibility
Schedule of Insurance-Benefits
Premiums
Participating Entities
Policy Provisions
Incorporation Provision]

Premium Provisions

The Schedule(s) of Insurance for The Policy benefits listed below are shown in the Certificate(s), as incorporated into The Policy.

- 1) [Basic Life Insurance
- 2) Supplemental Life Insurance
- 3) Accidental Death, Dismemberment and Loss of Sight Benefit
- 4) Supplemental Accidental Death, Dismemberment and Loss of Sight Benefit
- 5) Dependent Life Insurance
- 6) Spouse Accidental Death, Dismemberment and Loss of Sight Benefit
- 7) Short Term Disability Insurance
- 8) Long Term Disability Insurance
- 9) Supplemental Spouse Accidental Death Dismemberment and Loss of Sight Benefit]

The Schedule(s) of Insurance will control the:

- 1) [benefit amounts and maximum limits;
- 2) eligibility and effective date requirements; and
- 3) other schedule amounts and limits;

which apply to the employees of the Policyholder.]

Premium Provisions

Initial Monthly Premium Rates

The initial monthly premium rates to be charged [for employee Coverage and/or child/spouse coverage, if applicable, are shown on the following page(s).]

The first premium is due and payable on the effective date of The Policy. Subject to The Policy's grace period provision, all premiums after the first must be paid when or before they are due.

[Premiums are based on the Employee's:

- 1) age on his or her effective date and thereafter on the first day of the month following the month in which his or her birthday occurs;]
- 2) [sex and occupational class.]

[For Long Term Disability Benefits, the amount of an employee's Earnings which is disregarded in determining his Monthly Benefit because of the Maximum Monthly Benefit limitation will also be disregarded in determining the amount of the total insured payroll.]

The Initial Monthly Premium Rates may be converted as follows:

To Convert Rates to:	Use a Conversion Factor of:
-- annual rates	11.8227
-- semi-annual rates	5.9557
-- quarterly rates	2.9852

Grace Period

The Company will allow the Policyholder a [45] day grace period for the payment of all premiums after the first. During this [45] day period, The Policy will stay in force. If the owed premium is not paid by the [45th] day, The Policy will automatically terminate. If the Policyholder gives The Company written advance notice of an earlier cancellation date, The Policy will terminate on the earlier date. Premium is due for each day The Policy is in force.

[Monthly Premium Rate Guarantee

Initial Monthly Premium rates are guaranteed as follows:

Benefit	Rate Guarantee Period
[Basic Life Insurance	6 months
Basic Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Life Insurance	6 months
Supplemental Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Dependent Life Insurance	6 months
Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Long Short Term Disability Benefits Term Disability Benefits	6 months]

[Subject to the Rate Guarantee period shown above, The Company has the right to change premium rates on any premium due date if:

- 1) written notice is delivered to the Policyholder's last address on record; and
- 2) the change is effective at least [31] days after the date of notice.]

[The Rate Guarantee supersedes only those provisions appearing elsewhere in this policy which give The Company the right to change the premium rates, and then, only for the period of time for which the rates are guaranteed. However, The Company may change the premium rates during the Rate Guarantee period if there is a [10%] change in The Policy, or if there is an increase or decrease in the number of insured employees, or if the Policyholder adds or deletes a subsidiary or affiliated business entity. The Company may also change the premium rates during the Guarantee Period if there has been a material misstatement in the reported experience during the pre-sale process. The Rate Guarantee in no way affects, amends or supersedes any other provision in The Policy.]

Premium Provisions

Calculation

Premiums may be calculated by multiplying the rate times the applicable number of units of coverage.

If any insurance is added, increased or becomes effective after The Policy is in force, the premium charges will begin on:

- 1) the day the coverage is effective, if it is also the first day of a policy month; or
- 2) the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month. [With respect to Dependent Life Insurance only, the premium rate per Dependent Unit or per \$1,000 of insurance, whichever is applicable, will be based on actuarial assumptions, due to the difficulty in obtaining the ages of all Dependents who are covered under this benefit. The actuarial assumptions will produce, in the opinion of The Company, the same total amount of premium as would be obtained by the use of the actual ages of the Dependents covered.]

Premiums may be calculated by any other method which both The Company and the Policyholder agree to in writing.

Premium Payments

Premium payments are due and payable in full to a place designated by The Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of The Company. Payment of premiums for a period before it is due will not guarantee the insurance for that period.

[Experience Rating

If The Policy is experience rated, any credit amount due the Policyholder will be allowed on The Policy Anniversary Date and, at the Policyholder's request, will be:

- 1) paid to the Policyholder in cash;
- 2) used to reduce the Policyholder premiums; or
- 3) used to provide additional insurance for Covered Persons.

Any credit amount shall be determined by the rating plan or plans used by The Company.]

[Combined Experience

If the experience of The Policy is combined with other policies, it shall be combined only with the experience of the following Policies: XXXXX; XXXXX and XXXXX]

Premium Schedule

PREMIUM SCHEDULE

[Long Term Disability: PREMIUMS

Short Term Disability: PREMIUMS

Life Insurance: PREMIUMS

Accidental Death and Dismemberment: PREMIUMS]

Participating [Entities]

The Policyholder means [the Kanawha Insurance Disability Trust.]

Participating [Entity] means any [Entity] that has [become a member of the Kanawha Insurance Disability Trust.]

The Company or The Policyholder, by written request, may add to or delete from the list of Participating [Entities] in The Policy [at any time.] [The Company will keep a list of Participating [Employers] accepted by The Company and the effective dates of coverage for each.]

Any change, subject to The Company's written approval, will become effective [on a date which is mutually agreeable to the Policyholder and The Company.] The Policyholder may act for or on behalf of all Participating [Entities] in all matters of The Policy. The following will be binding on all Participating [Entities]:

- 1) all agreements between The Company and the Policyholder;
- 2) all notices from The Company to the Policyholder; and
- 3) all notices from the Policyholder to The Company.

Each reference in the Policy to a relationship between the Policyholder and its Eligible Persons includes the same relationship between each Participating [Entity] and its [Eligible Persons], except where the Policy describes specific differences.

Individual Effective Date: A person associated with a Participating [Entity] will not:

- 1) become an Eligible Person before the [Entity] qualifies; or
 - 2) continue as an Eligible Person after the [Entity] ceases to qualify;
- as a Participating [Entity].

Premiums: A Participating [Entity]'s premiums will be calculated based on:[

- 1) the coverage requested; and
- 2) the data given to The Company by the Participating [Entity].]

[Data Given by Participating [Entity]: The Participating [Entity], with our approval, may keep the important insurance records on all persons covered under The Policy. The Participating [Entity] or its designee must give The Company information, when and in the manner The Company asks, to administer the insurance provided by the Policy.

[The Participating [Entity] will, upon our request, give us:

- 1) the names of all persons initially eligible for coverage;
- 2) the names of all additional persons who become eligible for coverage;
- 3) the names of all persons whose amount of insurance is to be changed;
- 4) the names of all persons whose eligibility or insurance is terminated; and
- 5) any data necessary to administer the insurance provided by the Policy.]

The Participating [Entity]'s failure to:

- 1) give The Company the name of any person covered under The Policy will not invalidate such person's insurance;
- 2) [report a person's termination of insurance will not continue the coverage beyond the date of termination.]

The Policyholder's and/or Participating [Entity]'s insurance records will be open for our inspection at any reasonable time.

Upon termination of coverage, any unearned premium will be calculated on a pro-rata basis. The Company will promptly return any unearned premium paid.]

Participating [Entity] Termination Date: A Participating [Entity] will cease to be covered on the first to occur of:

- 1) [the date the Participating [Entity] ceases to be a member of the Policyholder;
- 2) the date requested by the Participating [Entity] but not prior to The Company's receipt of the request;
- 3) the termination date of the Policy;
- 4) the date the Participating [Entity]'s premium is due, but not paid; or
- 5) the date on which the Policyholder requests that the [Entity] be removed from The Policy. Such date must be stated in a written notice to The Company, and must be after the date of the notice.

Participating [Entities]

[Name of Participating [Entity]	Effective Date	Account Number	Termination Date
ABC [Entity]	January 1, 2004	000-00-0000]

]

Policy Provisions

Entire Contract:

The contract between the parties consists of:

- 1) the Policy;
- 2) any certificates incorporated and made a part of the Policy;
- 3) any riders, amendments or endorsements issued in connection with such certificates;
- 4) the Policyholder's application; and
- 5) any Written Medical Insurability Application submitted by the Eligible Person/Employee and accepted by The Company in connection with the Policy.

All statements made by the Policyholder, Participating [Entity] or persons insured under The Policy will be deemed representations and not warranties. No statement made to effect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary.

Incontestability:

Except for non-payment of premium, the insurance provided by The Policy cannot be contested after such insurance has been in effect for a period of [2 years.]

Changes: The Company reserves the right to make changes in the Policy, [after The Policy has been in force for 12 months.] The Company will give the Policyholder [31 days] advance written notice of any change. No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, approved by one of our officers and made a part of the Policy.

[30 Day Right to Examine Certificate: The Insured Person has a [30 day] right to examine his or her Certificate. If the [Insured Person] is not satisfied, he or she may return it to The Company within [30 days] of his or her effective date. In that event, The Company will consider it void from the certificate effective date and any premium paid will be refunded. Any claims paid under the Policy during the initial [30 day] period will be deducted from the refund.]

Clerical Error: Clerical error (whether by the Policyholder, the Plan Administrator, or us) in keeping the records having to do with the Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. A clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by the Policy. When a clerical error is found, premiums and benefits will be adjusted based on the true facts and the Policy.

Conformity with Law: If any provision of the Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law, including but not limited to the Federal Social Security Act, affects The Company's liability under The Policy, The Company may change The Policy, the premiums or both. Such change:

- 1) will be effective as of the date of the change to the state or federal law; and
- 2) will not be made until The Company gives the Policyholder [31 days] notice.

[Termination of Policy

The Company may terminate The Policy for the following reasons by giving the Policyholder [31] days written notice:

- 1) The Policyholder fails to furnish any information which The Company may reasonably require;
- 2) The Policyholder fails to perform any of his other obligations pertaining to this policy;
- 3) [Less than 100% of the persons eligible for coverage on a Non-contributory Basis are insured; or]
- 4) [Less than 75% of the persons eligible for coverage on a Contributory Basis are insured.]
- 5) [Fewer than 10 persons are insured.]

In addition, The Company may terminate this policy on any premium due date after The Policy has been in force for [12 months] by providing [31 days] written notice.

The Company reserves the right to terminate Dependent Life Insurance Benefits on any premium due date on which:

- 1) [there are fewer than 10 persons insured for Dependent Coverage; or]
- 2) [less than 75% of the persons eligible for Dependent Coverage on a Contributory Basis are insured.]

The Company shall give the Policyholder [31 days] notice of its intent to terminate the Dependent Life Insurance Benefit.]

Policy Provisions

[Cancellation: The Policy may be cancelled [at any time] by written notice mailed or delivered by The Company to the Policyholder, or by the Policyholder to us. If The Company cancels, The Company will mail or deliver the notice to the Policyholder at its last address shown in our records. If The Company cancels, it becomes effective [on the later of:

- 1) the date stated in the notice; or
- 2) the 31st day after The Company mails or delivers the notice.]

If the Policyholder cancels, it becomes effective [on the later of:

- 1) the date The Company receives the notice; or
- 2) the date stated in the notice.]

In either event:

- 1) The Company will promptly return to the Policyholder any unearned premium; or
- 2) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis. Cancellation will be without prejudice to any claim which commenced prior to the effective date of the cancellation.]

Certificates: The Company will give individual certificates to:

- 1) the Policyholder; or
- 2) any other person according to a mutual agreement among the other person, the Policyholder, and us;

for delivery to persons covered under The Policy and which will explain the important features of The Policy.

Data To Be Furnished

The Policyholder, or any other person designated by the Policyholder, will give The Company all information The Company needs regarding matters pertaining to the insurance. At any reasonable time while The Policy is in force and for [12 months] after that, The Company may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this policy.

The Policyholder will, upon our request, give us:

- 1) [the names of all persons initially eligible for coverage;
- 2) the names of all additional persons who become eligible for coverage;
- 3) the names of all persons whose amount of insurance is to be changed;
- 4) the names of all persons whose eligibility or insurance is terminated; and
- 5) any data necessary to administer the insurance provided by the Policy.]

If the Policyholder gives The Company any incorrect information, the relevant facts will be determined to establish if insurance is in effect and in what amount.

No person will be deprived of insurance to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the Policyholder. Any required adjustment may be made in premiums or benefits.

Right to Audit: The Company reserves the right to audit, [once every 2 years,] the Policyholder's billing records and premium accounting practices. If The Company discovers:

- 1) an underpayment of premium by the Policyholder, the Policyholder will be obligated to remit, in a timely manner, the underpayment amount; or
- 2) an overpayment of premium, The Company will return any overpayment amount in a timely manner;

for the previous [2 year period.]

[Not in Lieu of Worker's Compensation: This Policy does not satisfy any requirement for worker's compensation insurance.]

Time Period

All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

The Certificate(s) of Insurance [and Riders and Policy Changes] listed below are attached to, incorporated in and made a part of, this Policy.

<u>Certificate of Insurance</u> [XXXX]	<u>Applicable to:</u> [All Eligible Persons]	<u>Effective Date of Incorporation</u> [January 1, 2004]	<u>Termination Date</u> [January 1, 2005]
<u>Rider</u> [XXXX]	<u>Applicable to:</u> [All Eligible Persons]	<u>Effective Date of Incorporation</u> [January 1, 2004]	<u>Termination Date</u> [January 1, 2005]
<u>Policy Changes</u> Policy Page Added:[XXX] Policy Page Deleted: [XXX]	<u>Applicable to:</u> [All Eligible Persons] [All Eligible Persons]	<u>Effective Date of Change</u> [January 1, 2004] [January 1, 2004]	<u>Termination Date</u> [January 1, 2005]]

The provisions found in the Certificate will control the benefit plan, period of coverage, exclusions, claims and other general policy provisions pertaining to state insurance law requirements.

In all other respects, The Policy and certificates remain the same.

[INSERT COMPANY LOGO]

KANAWHA INSURANCE COMPANY
[210 SOUTH WHITE STREET, POST OFFICE BOX 610]
[LANCASTER, SOUTH CAROLINA 29721-0610]

TELEPHONE [1-800-635-4252]

CERTIFICATE OF GROUP LONG TERM DISABILITY INSURANCE

[Policyholder: Kanawha Insurance Disability Trust]

[Policy Number: XXX-XXXXXXX]

[Policy Effective Date: DATE]

[Policy Anniversary Date: DATE]

[Participating Entity]

[Account Number: XXXXXXXX]

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company



[Joan O. Lenahan]
[Vice President and Corporate Secretary]



[R. Dale Vaughan]
[President]

]]

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

[Table of Contents
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Schedule of Insurance
Definitions
Eligibility and Enrollment
Period of Coverage
Benefits
Exclusions
General Provisions]

Schedule of Insurance

[The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of DATE.

Cost of coverage:

[Option 1 - You do not contribute toward the cost of coverage].

[Option 2 - You must contribute toward the cost of coverage].

[Eligible Class(es) For Coverage:

All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.]

[Eligible Class(es) for Coverage: All [Full-time] [and] [Part-time] Active Employees working a minimum of –1000-2000] hours annually who are citizens or legal residents of the United States, [its territories and protectorates;] excluding temporary, leased or seasonal employees.

[Full-time Employment: at least [1000-2000] hours annually]

[Part-time Employment: at least [416-999] hours annually, but less than [1000-2000] hours annually]]

[Eligible Class(es) for Coverage: All [Full-time] and [Part-time] [Employees] who are subject to a collective bargaining agreement with [the Policyholder] who are working in the United States of America [,Puerto Rico, Guam and any other locations where We may legally provide such coverage]; excluding temporary, leased or seasonal employees.

[Full-time Employment: at least [24-40] hours weekly]

[Part time Employment: at least [8-30] hours weekly but less than [24-40] hours weekly]]

[Annual Enrollment Period: MONTH & DAY through MONTH & DAY.]

[Maximum Monthly Benefit: [The lesser of:]

- [\$1,000-\$20,000];
- [[20-75%] of your Pre-disability Earnings][; or]
- [your Scheduled Monthly Benefit.]]

[Guaranteed Issue Amount: [\$1,000-\$20,000]]

[Minimum Monthly Benefit: [the greater of:]

- 1) [\$25-\$100] [; or
- 2) [5-15%] of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.]]

[Scheduled Monthly Benefit (Monthly Benefit): An amount you elect in increments of [\$100-\$500.]

[Corresponding Scheduled Monthly Benefit Percentage: Your Scheduled Monthly Benefit divided by your Pre-disability Earnings.]

[Initial Benefit Period Percentage:

[Option 1: [20-75%]]

[Option 2: [20-75%]]

[Continuing Benefit Period Percentage:

[Option 1: [20-75%] of Pre-disability Earnings]

[Option 2: [20-75%] of Pre-disability Earnings]]

[Eligibility Waiting Period for Coverage:

[Option 1: [0-90] [days][weeks][months] of continuous service]

[Option 2: [0-90] [days][weeks][months] of continuous service]

You will be eligible for coverage on the first day of the month on or next following the date on which You complete the Eligibility

Schedule of Insurance

Waiting Period for Coverage.]]

[The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer in an eligible class under the Prior Policy.]

[Elimination Period:

[Option 1: [1-910] [day(s)][weeks][months][years]

[Option 2: [1-910] [day(s)][weeks][months][years]]

[Elimination Period:

Benefits Commence on the [8th-31st] consecutive day of Disability

For hospital confinements of 24 hours or more, benefits commence on the first day of hospital confinement.]

Maximum Duration of Benefits Table

[If Your Disability is the result of a Pre-existing Condition, the Maximum Duration of Benefits is [1 month], otherwise:]

[Age When Disabled

Prior to Age 62

Age 62

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 and over

Benefits Payable

To Age 65, or for 48 months, if greater

48 months

42 months

36 months

30 months

27 months

24 months

21 months

18 months]

[Age When Disabled

Prior to Age 62

Age 62

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 and over

Benefits Payable

To Age 65, or for 42 months, if greater

42 months

36 months

30 months

24 months

21 months

18 months

15 months

12 months]

[Age When Disabled

Prior to Age 63

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 and over

Benefits Payable

To Normal Retirement Age or for 48 months,
if greater

42 months

36 months

30 months

27 months

24 months

21 months

18 months]

[Age When Disabled

1696

Benefits Payable

Schedule of Insurance

Prior to Age 63	To Normal Retirement Age or for 42 months, if greater
Age 63	46 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

[Age When Disabled	Benefits Payable
Before Age 60	To age 65
Ages 60-64	60 months
Ages 65-67	To age 70
Age 68 and over	24 months]

[Age When Disabled	Benefits Payable
Before Age 68	To age 70
Age 68 and over	24 months]

[Age When Disabled	Benefits Payable
Prior to Age 60	To age 65 or for 60 months, if greater
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

[Age When Disabled	Benefits Payable
Prior to Age 61	60 months
Age 61	54 months
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months]

[Age When Disabled	Benefits Payable
prior to Age 66	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

Definitions

- [Actively at Work]** means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:
- 1) in the usual way; and
 - 2) for [Your usual number of hours.]
- [We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.]]
- [Active [Employee]]** means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.]]
- [Activities of Daily Living (ADLs)]** means the following functions performed with or without equipment or adaptive devices:
- 1) bathing Yourself by being able to either:
 - a) wash Yourself in a tub or shower devices; or
 - b) give Yourself a sponge bath;
 - 2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
 - 3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
 - 4) transferring from bed to chair or wheelchair; or
 - 5) bladder and bowel control by being able to either:
 - a) voluntarily control bowel and bladder function; or
 - b) maintain a reasonable level of person hygiene, if You are not so able; and
 - c) feeding Yourself, once the food has been prepared and made available to You.]
- [Any Occupation]** means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of:
- 1) [the product of Your Indexed Pre-disability Earnings and the [Initial] Benefit Period Percentage]; or
 - 2) [the Maximum Monthly Benefit.]]]
- [Bonuses]** means the [monthly average of monetary] bonuses You received from [the Employer] [over:
- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
 - 2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]]]
- [Cognitively Impaired or Cognitive Impairment]** means You suffer severe deterioration, or loss of:
- 1) memory;
 - 2) orientation; or
 - 3) the ability to understand or reason;
- so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.]
- [Commissions]** means the [monthly average of monetary] commissions You received from [the Employer] [over:
- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
 - 2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]]
- [Current Monthly Earnings]** means [Monthly] earnings You receive from:
- 1) [the Employer; and
 - 2) other employment;]
- while You are Disabled.
- [However, if the other employment is a job You held in addition to Your job with the Employer,

Definitions

then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly] Earnings.]

[Current [Monthly] Earnings also includes the pay You could have received for another job or a modified job or for increasing Your hours or duties to Your Maximum Capacity if:

- 1) such job or increase in hours or duties was offered to You by the Employer, or another employer, and You refused the offer; or
- 2) the requirements of the position were consistent with:
 - a) Your education, training and experience; and
 - b) Your capabilities as medically substantiated by Your Physician.]

[Current [Monthly][Weekly] Earnings do not include earnings from work performed prior to the Date of Disability.]

[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of Any Occupation as a result of:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy.]

[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

- 1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] during the Elimination Period; and
- 2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must result from:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[Reasonable Alternative Job means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]]

[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

- 1) Your Occupation during the Elimination Period;

Definitions

- 2) Your Occupation, for the [24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings;
- 3) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] after that, [for the next 12 months]; and
- 4) after that, Any Occupation .

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must be the result of:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[Reasonable Alternative Job] means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]]

Definitions

[[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

- 1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] during the Elimination Period;
- 2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] [for the 24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings; and
- 3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must result from:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[Reasonable Alternative Job means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]]

[Disability or Disabled

means Our determination that Your Sickness or Injury:

- 1) during the Elimination Period and for the first [24] months of Disability benefits, prevents You from performing with reasonable continuity the duties of Your Occupation [and a reasonable employment option offered to you by an employer][and, as a result, the income You are able to earn is less than or equal to [80%] of Your Pre-disability Earnings].
- 2) after the first [24] months of Disability benefits, prevents You from performing with reasonable continuity [two] or more Activities of Daily Living (ADLs), without stand-by help; or
 - a) you have a Cognitive Impairment; or
 - b) you have a Terminal Illness.]

[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

- 1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] during the Elimination Period;
- 2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] [for the 24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings; and

After the first [24] months of Disability benefits, You must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can

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be expected to result in death of which has lasted or can be expected to last for a continuous period of not less than 12 months.

A Substantial Gainful Activity is an activity of a nature generally performed or intended for pay or profit, involving significant physical or mental duties, or a combination of both, performed on a full or part-time basis.]

[Elimination Period] means the [longer of the] number of consecutive [days][months][years] at the beginning of any one period of Disability which must elapse before benefits are payable [or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law].]

[[Employer] means the [Participating Employer].]

[Essential Duty] means a duty that:

- 1) is substantial, not incidental;
- 2) is fundamental or inherent to the occupation; and
- 3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.]

Definitions

[Indexed Pre-disability Earnings]

means Your Pre-disability Earnings adjusted annually by adding the lesser of:

- 1) [10%;] or
- 2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for [12 consecutive months,] provided You are receiving benefits at the time the adjustment is made. [A maximum of [5] adjustments may be made.]

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W.]

[Injury]

means bodily injury resulting:

- 1) directly from accident; and
- 2) independently of all other causes;

[which occurs while You are covered under The Policy.] [However, an Injury will be considered a Sickness if Your Disability begins more than [30-365] days after the date of the accident.]]

[Maximum Capacity]

means the full utilization of Your capabilities in Any Occupation.]

[Mental Illness]

means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

- 1) Mental Retardation;
- 2) Pervasive Developmental Disorders;
- 3) Motor Skills Disorder;
- 4) Substance-Related Disorders;
- 5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- 6) Narcolepsy and Sleep Disorders related to a General Medical Condition.]

[[Monthly] Benefit]

means a [monthly] sum payable to You while You are Disabled, subject to the terms of The Policy. [Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.]]

[Monthly Income Loss]

means Your Pre-disability Earnings minus Your Current Monthly Earnings.]

[Other Income Benefits]

means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuant to any:

- 1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
- 2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
- 3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the

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result of membership in or association with any group, association, union or other organization;

- 4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
- 5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
- 6) [mandatory "no-fault" automobile insurance plan;]
- 7) disability benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act;that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or
- 8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
 - a) that begins after You become Disabled; or
 - b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

- 1) disability benefit under the Employer's Retirement plan;
- 2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
- 3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
- 4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
 - a) You were receiving it prior to becoming Disabled; or
 - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;(Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or
- 5) retirement benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
 - d) similar plan or act;that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.]

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

- 1) the amount attributed to loss of income; and
- 2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

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The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- 1) takes effect after the date benefits become payable under The Policy; and
- 2) is a general increase which applies to all persons who are entitled to such benefits.]]

Definitions

[Participating Employer]

means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.]

[Physician]

means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art who treats patients on a regular basis, that We recognize or are required by law to recognize;
- 2) licensed to practice and prescribe and administer drugs or to perform surgery in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You [or Your business partner] or Related to You by blood, marriage or adoption.]

[Pre-disability Earnings]

means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]:

- 1) the [monthly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for:
 - a) the [X tax] year(s) just prior to the date of Disability; or
 - b) the number of months You were employed in this capacity, if less than above period; and
- 2) [not] contributions You make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non-qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan, for the same period as above.

Pre-disability Earnings [does not] include [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital.]

[Pre-disability Earnings]

means, [for specific class description if applicable] Your average [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period:

- 1) [not] including contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and
- 2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense reimbursements for the same period as above.]

[Pre-disability Earnings]

means, [for specific class description if applicable], Your regular [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens],

- 1) [not] including contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and
- 2) [not] including [bonuses, commissions and tips and tokens] overtime pay or expense reimbursements for the same period as above.]

[However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:

- 1) the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by;
- 2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.]]

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[Pre-disability Earnings] means, [for specific class description if applicable] Your contracted [annual] rate of pay from Your Employer [plus income from your participation in other school related, extra-curricular activities,] divided by [12 months.]

Pre-disability Earnings shall:

- 1) [not] include contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and shall
- 2) [not] include income received from:
 - a) bonuses;
 - b) commissions;
 - c) overtime pay;
 - d) wages for extra-curricular school activities or programs;
 - e) Your employer's contribution on Your behalf to a retirement Plan or deferred compensation arrangement.]

[If we determine your earnings vary substantially from month to month, we may determine Your rate of pay by averaging Your earnings over the most recent [3] months.]]

[Prior Policy] means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date.]

[Regular Care of a Physician] means that You are being treated by a Physician:

- 1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
- 2) whose treatment is:
 - a) consistent with the diagnosis of the disabling condition;
 - b) according to guidelines established by medical, research, and rehabilitative organizations; and
 - c) administered as often as needed;to achieve the maximum medical improvement.]

[Rehabilitation] means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, [any necessary and feasible:

- 1) vocational testing;
- 2) vocational training;
- 3) alternative treatment plans such as:
 - a) support groups;
 - b) physical therapy;
 - c) occupational therapy; or
 - d) speech therapy;
- 4) work-place modification to the extent not otherwise provided;
- 5) job placement;
- 6) transitional work; and
- 7) similar services.]]

[Related] means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].]

[Retirement Plan] means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

- 1) [a profit sharing plan;
- 2) thrift, savings or stock ownership plans;
- 3) a non-qualified deferred compensation plan; or
- 4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k)

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plan, 403(b) plan or 457 deferred compensation arrangement.]]

[Sickness

means a Disability [or loss] which is:

- 1) caused or contributed to by:
 - a) any condition, illness, disease or disorder of the body;
 - b) any infection, except a pus-forming infection of an accidental cut or wound [or bacterial infection resulting from an accidental ingestion of a contaminated substance];
 - c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or
 - d) [pregnancy;] or
- 2) caused or contributed to by any medical [or surgical] treatment for a condition shown in item 1) above.]

[Special Condition

means musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of the joints and adjacent muscles, except arthritis; ruptured intervertebral discs; scoliosis; spinal fractures; osteopathies; spinal tumors, malignancy or vascular malformations; radiculopathies documented by electromyogram; spondyloisthesis, grade II or higher; myelopathies and myelitis; demyelinating diseases; or traumatic spinal cord necrosis.

Special Condition also includes chronic fatigue syndrome; fibromyalgia; carpal tunnel syndrome; environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity.]

[Substance Abuse

means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

- 1) impairments in social and/or occupational functioning;
- 2) debilitating physical condition;
- 3) inability to abstain from or reduce consumption of the substance; or
- 4) the need for daily substance use to maintain adequate functioning.

[Substance includes alcohol and drugs but excludes tobacco and caffeine.]]

[The Policy

means the policy which We issued to [The Policyholder under the policy number] shown on the face page.]

[Tips [and Tokens]

means the [monthly average of monetary] tips and tokens You received from [the Employer] [over:

- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
- 2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]]

Definitions

[Trust means [the trust fund established by Kanawha Insurance Company.]]

[We, Our, or Us means [the insurance company named on the face page of The Policy.]]

[Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

[If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.]

[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]

[You or Your means the person to whom this certificate is issued.]

Eligibility and Enrollment

[Eligible Persons: All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible
*Who is Eligible for
Coverage?* Persons.]

**[Eligibility for
Coverage:** When You will become eligible for coverage on the later of:
*will I become
Eligible?* 1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage.

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]]

[Enrollment: *How
do I enroll for
coverage?* [For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll.] To enroll [for coverage] You must:

- 1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
- 2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll [or if You enroll for a Monthly Benefit Amount greater than the Guaranteed Issue Amount]:]

- 1) You must give Us Evidence of Insurability satisfactory to Us; and
- 2) [You may only enroll:
 - a) during an [Annual Enrollment Period] designated by the Policyholder; or
 - b) within [31 days] of the date You have a Change in Family Status.]

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]]

**[Evidence of
Insurability:** *What
is Evidence of
Insurability?* Evidence of Insurability may include, but will not be limited to:
1) [a completed and signed application approved by Us;
2) a medical examination;
3) an attending Physician's statement; and
4) any additional information We may require.]

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.]

**[Change in Family
Status:** *What
constitutes a Change
in Family Status?* A Change in Family Status means:
1) [You get married [or You execute a domestic partner affidavit];
2) You and Your Spouse divorce [or You terminate a domestic partnership];
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse [or domestic partner] dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.]]

Period of Coverage

[Effective Date:
*When does my
coverage start?*

[If You are not required to contribute toward The Policy's cost,] Your coverage will start:
1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or
2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.]

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:
1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then;
2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible;
3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or]
4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.]]

**[Deferred Effective
Date:** *Will my
coverage start or an
increase in my
coverage take effect
if I am not Actively
at Work on the date
my coverage is to
start or increase?*

If You are absent from work due to:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) [pregnancy;]

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day.]

Period of Coverage

[Changes in Coverage: Can I change my benefit option?

[You may change Your benefit option only:

- 1) during an Annual Enrollment Period; or
- 2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

- 1) [the first day of the month following the Annual Enrollment Period;] or
- 2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:

- 1) the date You enroll for the change; or
- 2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:

- 1) Deferred Effective Date; and
- 2) Pre-existing Conditions Limitations.]]

[Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

- 1) are an Active Employee; and
- 2) are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.]

[What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:

- 1) the Deferred Effective Date provision; and
- 2) Pre-existing Conditions Limitations.]]

Period of Coverage

[Continuity From A Prior Policy: Is there continuity of coverage from a Prior Policy?

[If You were:

- 1) insured under the Prior Policy; and
- 2) not eligible to receive benefits under the Prior Policy;

on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]]

[Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

- 1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
- 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Monthly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

- 1) the [Monthly] Benefit which was paid by the Prior Policy; or
- 2) the [Monthly] Benefit provided by The Policy.]

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]]

[Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [monthly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] of Your return to work:

- 1) You have a recurrence of the same disability while covered under The Policy; and
- 2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.]

Period of Coverage

Termination:

When will my coverage stop?

Your coverage will end on the earliest of the following:

- 1) [the date] The Policy terminates;
 - 2) [[the date] The Policy no longer insures Your class;]
 - 3) [the date] premium payment is due but not paid by the Employer;
 - 4) [the last day of the period for which You make any required premium contribution;]
 - 5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;]
 - 6) [the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason;
 - 7) [the date Your Employer ceases to be a Participating Employer];
- unless coverage is extended under the Continuation Provisions.

Period of Coverage

[Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- 1) is subject to any reductions in the Policy;
- 2) is subject to payment of premium [by the Employer;] and
- 3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.]

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.]

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.]

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.]

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]]

Period of Coverage

[Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

- 1) [during the Elimination Period while You remain Disabled by the same Disability; and
- 2) after the Elimination Period for as long as You are entitled to benefits under The Policy.]]

[Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You:

- 1) [after the Elimination Period; and
- 2) for as long as benefits are payable.]]

[Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

- 1) will continue as long as You remain Disabled by the same Disability; but
- 2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.]

Period of Coverage

[Conversion Right:
*If my coverage
under the Policy
stops, do I have a
right to conversion?*

If Your insurance terminates because:

- 1) Your employment ends [for a reason other than Your retirement]; or
- 2) You are no longer in an eligible class;

and if:

- 1) [You have been continuously insured for at least [12 consecutive months] under The Policy or under both this Policy and the Prior Policy;]
- 2) [You are under the Policy Age Limit, if any is shown in the Schedule of Insurance;]
- 3) a Disability is not preventing You from performing duties of Your Occupation;
- 4) [the insurance for Your class, or] The Policy has not terminated;
- 5) [You are not eligible for coverage under The Policy under another class; and]
- 6) You are not eligible or covered for similar benefits under another group policy [or an individual policy];

then You are eligible to enroll for personal insurance under another group policy called the group long term disability conversion policy.]

*[How do I convert
my Coverage?*

To obtain coverage under the group long term disability conversion policy, You must:

- 1) send Us a written enrollment request; and
- 2) pay the required premium and enrollment fee for the conversion policy;

within [31 days] of the termination of Your insurance.

If You meet the preceding conditions, We will issue You a certificate of insurance under the group long term disability conversion policy. Such coverage will:

- 1) be issued without Evidence of Insurability;
- 2) be on one of the forms then being issued by Us for conversion purposes; and
- 3) be effective on the day following the date Your insurance under The Policy terminates.

The coverage available under the conversion policy may differ from The Policy. We will determine the terms of the group long term disability conversion policy, including:

- 1) the type and amount of coverage provided; and
- 2) the premium payable;

based on the kinds of insurance provided by the group long term disability conversion policy at the time such enrollment request is made.]

Benefits

[Disability Benefit:

When do I qualify for Disability Benefits?

We will pay You a Monthly Benefit if You:

- 1) become Disabled while insured under The Policy;
- 2) are Disabled throughout the Elimination Period;
- 3) remain Disabled beyond the Elimination Period; and
- 4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.]

[Mental Illness And Substance Abuse

Benefits: *Are benefits limited for Mental Illness [or Substance Abuse?]*

If You are Disabled because of:

- 1) Mental Illness that results from any cause;
- 2) any condition that may result from Mental Illness;
- 3) alcoholism [which is under treatment]; or
- 4) [the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance];

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

[Benefits will be payable for a total of [24 months,] unless at the end of the [24 month] period:

- 1) You are confined in a hospital or other place licensed to provide medical care for the disabling condition, in which case:
 - a) benefits will continue during the confinement; and
 - b) if You are still Disabled when discharged, benefits will continue for a recovery period of up to [90 days;] and
 - c) if You become re-confined during the recovery period for at least [14 consecutive days,] benefits will continue during the confinement and another recovery period of up to [90 days;]

or

- 2) You continue to be Disabled and, [within 7 days] become confined in a hospital, or other place licensed to provide medical care, for the disabling condition for at least [14 consecutive days,] in which case benefits will be paid while You are so confined.]]

[Substance Abuse Limitation:

Are benefits limited for alcoholism or Substance Abuse?

If You are Disabled because of:

- 1) alcoholism [under treatment]; or
- 2) the non-medical use of narcotics, [sedatives, stimulants, hallucinogens, or any other such substance];

then, subject to all other Policy provisions, benefits will be payable for [as long as] You are:

- 1) confined in a hospital or other place licensed to provide medical care for the disabling condition; or
- 2) actively participating in a rehabilitative program approved by Us.]

[Special Conditions

Limitation: *Are benefits limited for special conditions?*

If You are Disabled because of a Special Condition, as defined, then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

[Benefits will be payable for a total of [24 months,] unless at the end of the [24 month] period:

- 1) You are confined in a hospital or other place licensed to provide medical care for the disabling condition, in which case:
 - a) benefits will continue during the confinement; and
 - b) if You are still Disabled when discharged, benefits will continue for a recovery period of up to [90 days;] and
 - c) if You become re-confined during the recovery period for at least [14 consecutive days,] benefits will continue during the confinement and another recovery period of up to [90 days;]

or

- 2) You continue to be Disabled and, [within 7 days] become confined in a hospital, or other place licensed to provide medical care, for the disabling condition for at least [14 consecutive days,] in which case benefits will be paid while You are so confined.]]

Benefits

[Recurrent Disability:

What happens if I recover but become Disabled again?

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are [less than one-half (1/2) the number of days of Your Elimination Period.]

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

- 1) due to the same cause; or
- 2) due to a related cause; and
- 3) within [6] months of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [6] months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a New Maximum Duration of Benefits.]

[Period of Disability means a continuous length of time during which You are Disabled under The Policy.]

[Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.])

Benefits

[Calculation of Monthly Benefit:
How are my Disability benefits calculated [during the Initial Benefit Period]?

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefit [during the Initial Benefit Period] as follows:

- 1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage;
- 2) compare the result with the Maximum Benefit ; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

How are Disability benefits calculated?

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefits as follows:

- 1) multiply Your Monthly Income Loss by the Benefit Percentage;
- 2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage; and from this product subtract all Other Income Benefits; and
- 3) identify the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

[While You are participating in a program of Rehabilitation approved by Us, We will increase Your Monthly Benefit, as calculated above, by [10%], not to exceed the Maximum Benefit.]]

[Calculation of Monthly Benefit: Return to Work Incentive:
How are my Disability benefits calculated?

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows:

- 1) multiply Your Pre-Disability Earnings by the [Initial] Benefit [Period] Percentage;
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The [12 consecutive month] period will start on the last to occur of:

- 1) the day You first start work; or
- 2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, [during the Initial Benefit Period,] We will calculate Your Monthly Benefit as follows:

- 1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage;
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

[While You are participating in a program of Rehabilitation approved by Us, We will increase Your Monthly Benefit, as calculated above, by [10%], not to exceed the Maximum Benefit.]]

[Calculation of Monthly Benefit: Return to Work Incentive:
How are my Disability benefits calculated?

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows:

- 1) multiply Your Pre-disability Earnings by the Benefit Percentage;
- 2) multiply Your Pre-disability Earnings by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
- 3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit during this period. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

If You are Disabled, but You are not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

- 1) multiply Your Monthly Income Loss by the Benefit Percentage;

Benefits

- 2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
- 3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

During the Continuing Benefit Period, if [You are not receiving benefits under the Return to Work Incentive, but] You are receiving benefits under Social Security Disability or Social Security Retirement plans, or an alternative plan for federal, state or municipal employees, We will determine Your Monthly Benefit as follows:

- 1) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage;
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

During the Continuing Benefit Period, if You are not receiving benefits [under the Return to Work Incentive, or] under Social Security Disability or Social Security Retirement plans or an alternative plan for federal, state or municipal employees, We will determine Your Monthly Benefit as follows:

- 1) multiply Your Pre-disability Earnings by the Continuing Benefit Period Percentage;
- 2) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage, and deduct all Other Income Benefits; and
- 3) deduct all Other Income Benefits from the Maximum Benefit.

The result of the calculation giving the least amount is Your Monthly Benefit.

[While You are participating in a program of Rehabilitation approved by Us, We will increase Your Monthly Benefit, as calculated above, by [10%], not to exceed the Maximum Benefit.]]

[Calculation of Monthly Benefit: Return to Work Incentive: How are my Disability benefits calculated?]

If you remain Disabled after the Elimination Period, but work while you are Disabled, we will pay a Monthly Benefit for a period of up to 12 consecutive months as follows:

1. compare the Scheduled Monthly Benefit with the Maximum Monthly Benefit; and
2. from the lesser amount, deduct Other Income Benefits.

Current Monthly Earnings will not be used to reduce your Monthly Benefit. However, if the sum of your Monthly Benefit and your Current Monthly Earnings exceeds 100% of your Pre-disability Earnings, we will reduce your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1. the day you first start such work; or
2. the end of the Elimination Period.

If you are Disabled and not receiving benefits under the Return to Work Incentive, we will calculate your Monthly Benefit as follows:

1. multiply your Monthly Income Loss by the Corresponding Scheduled Monthly Benefit Percentage;
2. compare the Monthly Income Loss result with the Maximum Monthly Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

The result is your Monthly Benefit.

[While You are participating in a program of Rehabilitation approved by Us, We will increase Your Monthly Benefit, as calculated above, by [10%], not to exceed the Maximum Benefit.]]

[Calculation of Monthly Benefit: What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-

If the sum of Your [Monthly Benefit, Current Monthly Earnings and Other Income Benefits] exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.

[However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.]

[If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.]]

Benefits

disability Earnings?

[Minimum Monthly Benefit: Is there a Minimum Monthly Benefit?

Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

[The Scheduled Monthly Benefit, Corresponding Scheduled Monthly Benefit Percentage and Minimum and Maximum Monthly Benefit amounts are shown in the Schedule of Insurance.]]

[Partial Month Payment: How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

[The Scheduled Monthly Benefit, Corresponding Scheduled Monthly Benefit Percentage and Minimum and Maximum Monthly Benefit amounts are shown in the Schedule of Insurance.]]

[Denial of Social Security Benefits: After the Initial Benefit Period expires, is there any allowance if I am ineligible for Social Security?

If Your Disability prevents You from performing the Essential Duties of Any Occupation, but Your claim for disability benefits under The United States Social Security System, or an alternative plan for federal, state or municipal employees:

- 1) was denied because You have not worked under these systems long enough to be eligible for disability benefits, Your Monthly Benefit during the Continuing Benefit Period will be calculated using the Initial Benefit Period Percentage; or
- 2) is still pending at the time the Initial Benefit Period expires, benefits may be paid at the Initial Benefit Period Percentage until the earlier to occur of:
 - a) the 12th month following the expiration of the Initial Benefit Period; or
 - b) the final adjudication of Your claim for Social Security disability benefits.]

Benefits

Termination of Benefit Payment:

*When will my benefit
payments end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]]
- 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
- 5) the date of Your death;
- 6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.]
- 7) [the last day benefits are payable according to the Maximum Duration of Benefits Table; or]
- 8) [the date Your Current Monthly Earnings:
 - a) are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation [or a Reasonable Alternative]; or
 - b) [are greater than the lesser of: the product of Your [Indexed] Pre-disability Earnings and the [Initial] Benefit [Period] percentage; or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;]]]
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
- 10) [the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
 - a) [modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
 - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
 - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
 - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation;]] or]
- 11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
 - a) You were receiving them prior to becoming Disabled; or
 - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]]

Benefits

[Family Care Credit Benefit:

What if I must incur expenses for Family Care Services in order to participate in Rehabilitation?

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

- 1) Family Care means the care or supervision of:
 - a) Your children under age [13]; or
 - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- 2) the maximum monthly deduction allowed for each qualifying child or family member is:
 - a) [\$350] during the first [6] months of Rehabilitation ; and
 - b) [\$175] thereafter;but in no event may the deduction exceed the amount of Your monthly earnings;
- 3) Family Care Credits may not exceed a total of [\$2,500] during a calendar year;
- 4) the deduction will be reduced proportionally for periods of less than a month;
- 5) the charges for Family Care must be documented by a receipt from the caregiver;
- 6) the credit will cease on the first to occur of the following:
 - a) You are no longer in a Rehabilitation program; or
 - b) Family Care Credits for [24] months have been deducted during Your Disability; and
- 7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed [80%] of Your [Indexed] Pre-disability Earnings.]]

[Cost-Of-Living Adjustment: *How do my benefits keep pace with inflation?*

We [will] adjust Your Monthly Benefit for increases in the cost-of-living if:

- 1) You have been Disabled for [12 consecutive months]; and
- 2) [You are receiving benefits;] [and
- 3) Your Current Monthly Earnings are less than or equal to 20% of Your Pre-disability Earnings;]

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.]

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

- 1) [determining the lesser of:
 - a) [3%]; or
 - b) [1/2] the percentage change in the Consumer Price Index;
- 2) multiplying the resulting percentage (%) times the Monthly Benefit for Disability being received; and
- 3) adding the resulting amount to Your Monthly Benefit.]

When will the Cost-of-Living Adjustments end?

You will not receive a Cost-of-Living Adjustment after:

- 1) You cease to be Disabled; [or
- 2) You have received [5] adjustments;] or
- 3) The Policy terminates.

[Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered].

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.]]]

Benefits

[Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability Benefits?*

If You were receiving a Monthly [Disability] Benefit at the time of Your death [and You had been receiving such benefits [for at least 12 months]], We will pay a [Survivor Income Benefit], when We receive proof satisfactory to Us:

- 1) of Your death; and
- 2) that the person claiming the benefit is entitled to it.

[We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.]

[[We will pay the Survivor Income Benefit:

- 1) to the beneficiary You designated; or
- 2) if no beneficiary has been designated:
 - a) to Your Surviving Spouse; or
 - b) if no Surviving Spouse, in equal shares to Your Surviving Children;
 - c) [if no Surviving Spouse or Surviving Children, to Your estate.]

[If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.]

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

[The Survivor Income Benefit [will be equal to [3] times your Monthly Benefit/is calculated as [3] times the lesser of]:

- 1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
- 2) The Maximum Monthly Benefit.]

[To designate or change Your designation of beneficiary, You must file a written notice with Us on any form satisfactory to us. Whether You are living or not, any change will relate back and take effect as of the date You signed the written notice. We are not liable for payment of benefits made before receiving written notice.]

Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. ["Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.]

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance who are under age [19]. The term Surviving Children will also include any other children related to You by blood or marriage [or domestic partnership] and who:

- 1) lived with You in a regular parent-child relationship; and
- 2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

[In the event that You are diagnosed with a Terminal Illness while You are:

- 1) eligible for a Monthly Benefit under the Policy; and
- 2) at least [6] Monthly Benefit Payments remain payable to You;

We will pay the Survivor Income Benefit to You on an accelerated basis in one lump sum if:

- 1) [You submit a request that the Survivor Income Benefit be paid on an accelerated basis; and
- 2) We receive proof that You have been diagnosed with a Terminal Illness.

If the Survivor Income Benefit is paid on an accelerated basis, no additional benefit will be payable under this benefit upon Your death.]

Benefits

[Terminal Illness or Terminally Ill means a life expectancy of [6] months or less.]]

[Extended Earnings Protection Benefit:
Will benefits continue to be paid after my return to work if my earnings are less than Pre-disability Earnings?

This benefit protects Your earnings level after You have returned to work following a period of Disability. To qualify for this Extended Earnings Protection Benefit, You must:

- 1) have been Disabled under The Policy and received a Monthly Benefit from Us;
- 2) now be working [Full-time] for the Employer [or another employer;]
- 3) be performing all the Essential Duties of Your Occupation [or another occupation;]
- 4) as a result of having been so Disabled, be currently earning less than [80%] of Your Pre-disability Earnings; and
- 5) provide to Us each month, satisfactory proof of Your Current Monthly Earnings.

The Extended Earnings Protection Benefit will be the lesser of:

- 1) the Maximum Monthly Benefit ; or
- 2) Your Monthly Income Loss multiplied by the [Initial] Benefit [Period] Percentage.

The Extended Earnings Protection Benefit will end on the earliest of:

- 1) the date benefits have been payable for a maximum duration of [24] months;
 - 2) the date You are earning at least [80%] of Your Pre-disability Earnings; or
- the date You fail to submit to Us satisfactory proof of Your Current Monthly Earnings.]

[Workplace Modification Benefit:
Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

- 1) Your Disability is covered by this Policy;
- 2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
- 3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such workplace modification shall not exceed the amount equal to the amount of the Maximum Monthly Benefit.

We have the right, at Our expense, to have You examined or evaluated by:

- 1) a Physician or other health care professional; or
- 2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

- 1) the proposed modifications made on Your behalf are complete;
- 2) We have been provided written proof of the expenses incurred to provide such modification; and
- 3) You have returned to work as an Active Employee.

[Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this Policy.]]

Benefits

[Pension Contribution Benefit: *Does The Policy also cover contributions to a Pension Plan?*

[If You:

- 1) become Disabled while You are covered under this Pension Contribution Benefit;
- 2) remain Disabled for [365 days] of one continuous period of Disability; and
- 3) are receiving a Monthly Benefit under The Policy;]

We will pay a monthly Pension Contribution Benefit to the trustee or administrator of Your Pension Plan for deposit to Your pension account. The Pension Contribution Benefit will be [the least of:

- 1) [15%] of Your monthly Pre-disability Earnings;
- 2) [\$2,500];
- 3) the amount of the average monthly tax deferred contributions the Employer made to Your Pension Plan during the [12 calendar months] prior to becoming Disabled.]

We will make payments under this benefit according to the rules and regulations of the Internal Revenue Service and the provisions of Your Pension Plan. We will make any such payment that cannot be paid to the trustee or administrator of Your Pension Plan to a deferred annuity account designated by You.

No Pension Contribution Benefit will be payable after Your Monthly Benefit terminates.

[Pension Plan means, for the purpose of this Pension Contribution Benefit, a qualified defined contribution pension Plan, profit sharing Plan, or other Plan approved by Us, in which You are participating as a result of Your employment with the Employer.])

[Infectious And Contagious Disease Benefit: *If it is disclosed that I carry an Infectious and Contagious Disease, will The Policy cover the income lost as the result of limitations placed on my license or reduced patronage?*

You will be eligible to receive an Infectious and Contagious Disease Benefit when You have been covered by this benefit for a period of [12 months], and You provide verification that:

- 1) You carry an Infectious and Contagious Disease; and
- 2) You first tested positive for the Infectious and Contagious Disease after the effective date of this benefit; and
- 3) You are not Disabled but one or more of the following has happened:
 - a) Your license to practice Your Occupation has been revoked; or
 - b) You or Your license have limitations or restrictions imposed, and as a result You are unable to perform all of the Essential Duties of Your Occupation; or
 - c) it has been disclosed that You are infected with an Infectious and Contagious Disease; and
- 4) throughout a period of time equal in length to the [Elimination Period,] You have suffered a loss of earnings in excess of [20]% of Your Pre-disability Earnings immediately prior to disclosure; and
- 5) You have never refused to be immunized against the Infectious and Contagious Disease for which You are claiming this benefit.

What qualifies as an Infectious and Contagious Disease?

To qualify as an Infectious and Contagious Disease, a disease must be:

- 1) categorized by the Center for Disease Control as Infectious and Contagious; and
- 2) life threatening to You or persons with whom You may come in contact.

What will my monthly benefit be?

[We calculate the benefit as the lesser of;

- 1) the Maximum Monthly Benefit; or
- 2) Your earnings loss multiplied by the [Initial] Benefit [Period] Percentage.

Your earnings loss is determined by deducting Your Pre-disability Earnings after disclosure from Your Pre-disability Earnings prior to disclosure.]

Benefits

How long may an Infectious and Contagious Disease Benefit be paid?

We will stop paying this benefit on the earliest of:

- 1) the date Your Pre-disability Earnings are equal to or greater than [80]% of Your Pre-disability Earnings prior to disclosure;
- 2) the date You die;
- 3) the date You become eligible for Disability benefits under the terms of this Policy;
- 4) the date We determine You have not made every effort to continue to work in Your Occupation [on a full-time basis];
- 5) the date You no longer participate with Us in seeking and applying for suitable alternate work based on Your training, education, experience, and comparable income;
- 6) the end of the Maximum Duration of Benefits [Table/Payable] of The Policy; or
- 7) [the end of [2 years] from the date this benefit begins.]]

[Activities of Daily Living Benefit:

What is the Activities of Daily Living Benefit?

We will pay You the Activities of Daily Living Benefit if:

- 1) a Monthly Benefit is payable;
- 2) You become Cognitively Impaired or unable to perform [two or more] Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
 - a) [during or after the Elimination Period, and]
 - b) for at least [30 consecutive days;] and
- 3) the Disability and such impairment or inability begins while You are covered under this benefit.

The Activities of Daily Living Benefit will be [10% of Your Monthly Income Loss, but not greater than the lesser of:

- 1) [\$5000]; or
- 2) the Maximum Monthly Benefit.]

[The maximum payment period for this benefit will be [X years].]

[We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Activities of Daily Living Benefit for each day of covered loss.]

The Activities of Daily Living Benefit will not:

- 1) be reduced by Other Income Benefits;
- 2) increase or reduce other benefits under The Policy; [or
- 3) be subject to the Cost of Living Adjustment.]

You are not restricted in any way as to Your use of this Activities of Daily Living Benefit.

We will stop paying You the Activities of Daily Living Benefit on the date:

- 1) Your Monthly Benefit terminates;
- 2) You are not Cognitively Impaired and You are able to perform [five or more] ADLs;[or
- 3) You reach the maximum payment period shown in this benefit.]]

[Accidental Dismemberment and Loss of Sight Benefit: What

benefits are payable

If, while covered under The Policy, You sustain an accidental bodily injury, which results in any of the following Losses within [90 days] after the date of accident, We will pay the Monthly Benefit, after the Elimination Period, for at least the number of months shown opposite the Loss.

Benefits

*for dismemberment
or loss of sight due
to an Injury?*

For Loss of	Minimum Number of Monthly Benefit Payments
[Both Eyes	46
Both Hands or Both Feet	46
One Hand and One Foot	46
One Hand and One Eye	46
One Foot and One Eye	46
One Hand or One Foot	23
One Eye	15
Thumb and Index Finger of Either Hand	12]

[Loss means, with regard to:

- 1) hands and feet, actual severance through or above wrist or ankle joints;
- 2) eyes, entire and irrecoverable Loss thereof;
- 3) thumb and index finger, actual severance through or above the metacarpophalangeal joints.]

If You incur more than one of the listed Losses as the result of the same accident, the number of monthly benefit payments that You will receive will be limited to the Loss for which the greatest number of monthly benefit payments are shown in the above Schedule.

Benefits may continue to be payable to You after the Minimum Number of Monthly Benefit Payments have been made, if You remain Disabled. If You die after the Elimination Period, but before the minimum number of monthly benefit payments have been made, the remaining monthly benefit payments will be made to Your estate.]]

Benefits

[Business Protection Benefit:
Are additional Disability Benefits paid to compensate for business revenue lost when I am Disabled?

We will pay a [Monthly] Business Protection Benefit to the Employer if You:

- 1) are actively engaged on a full-time basis in the business of the Employer, and fall within a class of persons that is covered by The Policy, and You are:
 - a) the sole proprietor of the Employer if the Employer is a sole proprietorship; or
 - b) a general partner of the Employer if the Employer is a partnership; or
 - c) a Member of a Limited Liability Company if the Employer is a Limited Liability Company; and
- 2) become Disabled while You are covered under this Business Protection Benefit; and
- 3) remain Disabled for the longer of:
 - a) the Elimination Period; or
 - b) [90] consecutive days; and
- 4) are receiving a [Monthly] Benefit for the Disability under the group insurance policy.

Is a benefit paid if I am Disabled and Working?

We calculate the [Monthly] Business Protection Benefit as the [lesser of:

- 1) [15]% of Your [Pre-disability Earnings]; or
- 2) [\$2,500].]

[If You are Disabled and Working, We will proportionately reduce the Business Protection Benefit according to the following formula:

$$\text{Business Protection Benefit Payable} = \frac{(A - B) \times C}{A}$$

where

A = Your Pre-Disability Earnings

B = Your current [Monthly] earnings

C = The Business Protection Benefit payable if You were Totally Disabled.]

How long will this benefit be paid?

We will stop paying the Business Protection Benefits on the earliest of:

- 1) [the date You cease to be Disabled;
- 2) the date [12 monthly] benefits have been paid under this Benefit;
- 3) the date You cease to be the proprietor, a partner, or a [Member,]if applicable, of the Employer; or
- 4) the date You die.

In no event will this benefit continue to be payable beyond a date shown in the Termination of Benefit Payment provision.]]

[Medical Premium Supplement Benefit: Does The Policy also cover premium contributions for continuance of Medical coverage?

If You:

- 1) become Disabled while You are covered under this Medical Premium Supplement Benefit;
- 2) are receiving a Monthly Benefit under The Policy; and
- 3) [have experienced a COBRA qualifying event and have elected COBRA continuance of [Your Employer's] Medical Plan] [are an active participant in [Your Employer's] Medical Plan] on the date You become Disabled and incur out-of-pocket expenses as a result of Your election to continue coverage under that Medical Plan;
- 4) have not had a lapse in Your [COBRA coverage] [coverage under [Your Employer's]] Medical Plan during the elimination period; and
- 5) are not eligible for Medicare,

We must pay a [Monthly] [semi-monthly] Medical Premium Supplement Benefit to [You] [[Your Employer] on Your behalf.] The Medical Premium Supplement Benefit will be [the lesser of]:

- 1) [\$[X] per month] [;or]
- 2) the actual amount of premium You pay to [Your Employer] to continue coverage [under Your Medical Plan] [pursuant to COBRA].

You will cease to receive a Medical Premium Supplement Benefit when:

- 1) You cease to be Disabled; [or
- 2) You have received payments under this benefit for [X months;]]
- 3) [Your coverage under [Your Employer's] Medical Plan ends due to Your failure to pay premiums for that coverage;]

Benefits

- 4) [COBRA continuance under [Your Employer's] Medical Plan ends for any reason;]
- 5) You fail to provide satisfactory proof [on a quarterly basis] that You are making premium payments to [Your Employer] for [COBRA] continuation of Your Medical Plan;
- 6) You obtain coverage for Yourself [or Your dependents] under another group Medical Plan; [or
- 7) The Policy terminates].]

[**COBRA** means the Consolidated Omnibus Reconciliation Act of 1985, as amended, including changes made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).]

[**Medical Plan** means a program that:

- 1) provides health insurance or medical coverage to Your [and Your dependents]; and
- 2) for which You are eligible as a result of employer with [the Employer].

Medical Plan does not include:

- 1) [coverage for Your dependents];
- 2) accident-only or disability income insurance;
- 3) [limited scope,] [dental,] [vision,] benefits];
- 4) long term care/nursing home care/home health care coverage or any combination thereof;
- 5) Medicare supplemental coverage;
- 6) Specified disease coverage;
- 7) Hospital confinement indemnity insurance; or
- 8) Other similar types of insurance coverage designed to provide limited, incidental or supplemental benefits.]

[Payment of the Medical Premium Supplement Benefit will not result in any reduction of Your Monthly Benefit.] [If the sum of Your Monthly Benefit, Current Monthly Earnings, if You are not receiving benefits under the Return to Work Incentive, and the Medical Premium Supplement Benefits exceeds 100% of Your [Indexed] Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.] [However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.]

This benefit is subject to all other applicable terms and conditions of The Policy.

If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Medical Premium Supplement Benefit for each day You were Disabled.

Benefits

[Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:

The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.]

[Rehabilitation Bonus: What happens if I successfully complete an approved program of Rehabilitation?

If You successfully complete an approved program of Rehabilitation, You will be eligible for an additional benefit equal to [1] times Your Monthly Benefit.

The benefit will be subject to all applicable terms and conditions of the Policy. We will pay the benefit in one lump sum.]

[Progressive Illness Benefit: Does The Policy provide a benefit if I am diagnosed with a Progressive Illness?

If You are diagnosed with a Progressive Illness [after You become covered for this benefit under this Policy] and provide us with satisfactory proof from Your Physician of a Progressive Illness, You will be eligible for this Progressive Illness Benefit.

Progressive Illness means a noninfectious disease or disorder of indefinite duration that causes the afflicted person to gradually become Disabled as the disease or disorder becomes more severe or the symptoms of the disease become more frequent and impact the afflicted person's ability to perform his or her Own Occupation.

If You become Disabled from a Progressive Illness, Your Pre-disability Earnings will be [the greater of:

- 1) Your Pre-disability Earnings at the time you provide us with satisfactory proof from Your Physician of Your Progressive Illness; or
- 2) Your Pre-disability Earnings at the time you become Disabled under this Policy.]

Any benefits for Disability caused by a Progressive Illness will be calculated by using Your Pre-disability Earnings as determined above, and all other terms and conditions of the Policy in effect on the date of Your Disability.

Until such time as You are Disabled under the terms of this Policy, Your premiums will be calculated based on [the greater of:

- 1) Your Pre-disability Earnings under this Benefit; or
- 2) Your Pre-disability Earnings under the terms of this Policy.

Your Premium will not drop below the amount being paid at the time proof of Your Progressive illness is submitted, unless You qualify for Waiver of Premium under this Policy.]]

Exclusions and Limitations

[Exclusions: *What Disabilities are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability:

- 1) unless You are under the Regular Care of a Physician;
- 2) that is caused [or contributed to by] war or act of war (declared or not);
- 3) caused by Your commission of or attempt to commit a felony;
- 4) caused or contributed to by Your being engaged in an illegal occupation;
- 5) caused [or contributed to] by an intentionally self-inflicted [Injury];
- 6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer;
- 7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
- 8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

- 1) was sponsored by the Employer; and
- 2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]]

[Pre-Existing Condition

Limitation: *Are benefits limited for Pre-existing Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You become Disabled:

- 1) You have not received Medical Care for the condition for [365] consecutive day(s)] while insured under The Policy; or
- 2) [You have been continuously insured under The Policy for [730] consecutive day(s).]

[Pre-existing Condition means:

- 1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or
- 2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the [365] day period that ends the day before:

- 1) Your effective date of coverage; or
- 2) the effective date of a Change in Coverage].

[Medical Care is received when a physician or other health care provider:

- 1) is consulted or gives medical advice; or
- 2) recommends, prescribes, or provides Treatment.]

[Treatment includes but is not limited to:

- 1) medical examinations, tests, attendance or observation; and
- 2) use of drugs, medicines, medical services, supplies or equipment.]

General Provisions

Notice of Claim:

When should I notify the Company of a claim?

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.]

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim.

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within [15 days] after We receive a notice of claim.]

Proof of Loss:

What is Proof of Loss?

[Proof of Loss may include but is not limited to the following:

- 1) documentation of:
 - a) the date Your Disability began;
 - b) the cause of Your Disability;
 - c) the prognosis of Your Disability;
 - d) Your Pre-disability Earnings, Current [Monthly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
 - e) evidence that You are under the Regular Care of a Physician;
- 2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 3) the names and addresses of all:
 - a) Physicians or other qualified medical professionals You have consulted;
 - b) hospitals or other medical facilities in which You have been treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;
- 4) Your signed authorization for Us to obtain and release:
 - a) medical, employment and financial information; and
 - b) any other information We may reasonably require;
- 5) Your signed statement identifying all Other Income Benefits; and
- 6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.] All proof submitted must be satisfactory to Us.

[Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

- 1) meet and interview with our representative; and
- 2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

- 1) at Our expense; and
- 2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.]

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible; but
- 3) not later than [1 year] after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request.

General Provisions

Claim Payment:
*When are benefit
payments issued?*

When We determine that You;

- 1) are Disabled; and
- 2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as Proof of Loss satisfactory to Us is received].

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid:
*To whom will
benefits for my
claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent;

then We may pay up to [\$1,000] to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial:
*What notification
will I receive if my
claim is denied?*

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the Policy provisions on which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

Claim Appeal:
*What recourse do I
have if my claim is
denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

- 1) You must request a review upon written application within:
 - a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) You may request copies of all documents, records, and other information relevant to Your claim; and
- 3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

General Provisions

[Social Security:
*When must I apply
for Social Security
Benefits?*

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

- 1) to follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

**[Benefit
Estimates:** *How
does the Company
estimate Disability
benefits under the
United States
Social Security
Act?*

We reserve the right to reduce Your [Monthly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly] Benefit by the estimated amount. Your [Monthly] Benefit will not be reduced by estimated Social Security disability benefits if:

- 1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
- 2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
- 3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly] Benefit by an estimated amount and:

- 1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
- 2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.]

[Overpayment:
*When does an
overpayment
occur?*

An overpayment occurs:

- 1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
- 2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- 1) [retroactive awards received from sources listed in the Other Income Benefits definition;
- 2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
- 3) misstatement;
- 4) fraud; or
- 5) any error We may make.]]

**[Overpayment
Recovery:** *How
does the Company
exercise the right to
recover
overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.]

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
 - a) [You;

General Provisions

- b) any other organization;
 - c) any other insurance company;
 - d) any other person to or for whom payment was made; and
 - e) Your estate.]
- 2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered;
 - 3) refer Your unpaid balance to a collection agency; and pursue and enforce all legal and equitable rights in court.]

[Subrogation:
*What are the
Company's
subrogation rights?*

If You:

- 1) suffer a Disability because of the act or omission of a Third Party;
- 2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
- 3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.]

[Reimbursement:
*What are the
Company's
Reimbursement
Rights?*

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

- a) a legal judgment;
- b) an arbitration award; or
- c) a settlement or otherwise;

You must reimburse Us for the lesser of:

- a) the amount of payment made or required to be made by Us; or the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.]

Legal Actions:
*When can legal
action be taken
against Us?*

Legal action cannot be taken against Us:

- 1) sooner than [60 days] after the date proof of loss is given; or
- 2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud:
*How does the
Company deal with
fraud?*

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud.

Misstatements:
*What happens if
facts are misstated?*

If material facts about You were not stated accurately:

- 1) Your premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.]

**[Policy
Interpretation:**

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of

General Provisions

Who interprets the terms and conditions of The Policy?

The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).]

[INSERT COMPANY LOGO]

KANAWHA INSURANCE COMPANY
[210 SOUTH WHITE STREET, POST OFFICE BOX 610]
[LANCASTER, SOUTH CAROLINA 29721-0610]

TELEPHONE [1-800-635-4252]

CERTIFICATE OF GROUP SHORT TERM DISABILITY INSURANCE

[Policyholder: Kanawha Insurance Disability Trust]

[Policy Number: XXX-XXXXXXX]

[Policy Effective Date: DATE]

[Policy Anniversary Date: DATE]

[Participating Entity]

[Account Number: XXXXXXXX]

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company



[Joan O. Lenahan]
[Vice President and Corporate Secretary]

]]



[R. Dale Vaughan]
[President]

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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Schedule of Insurance

[The Policy of short term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of DATE.

[Cost of Coverage:

[Option 1 - You do not contribute toward the cost of coverage.]

[Option 2 - You must contribute toward the cost of coverage.]

[Eligible Class(es) For Coverage: All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.]

[Eligible Class(es) For Coverage: All [Full-time][Part-time] Active [Employees] who are subject to a collective bargaining agreement with [the Policyholder] who are working in the United States of America[, Puerto Rico, Guam and any other locations where We may legally provide such coverage]; excluding temporary, seasonal or leased employees.

[Full-time Employment: at least [24-40] hours weekly]

[Part-time Employment: at least [8-30] hours weekly but less than [24-40] hours weekly]]

[Eligible Class(es) For Coverage: All [Full-time][Part-time] Active [Employees] Working a Minimum of [1000-2000] Hours Annually who are citizens or legal residents of the United States, [its territories and protectorates,] excluding temporary, leased or seasonal employees.

[Full-time Employment: at least [1000-2000] hours annually]

[Part-time Employment: at least [416-999] hours annually but less than [1000-2000] hours annually]]

[Weekly Benefit: The lesser of:

- 1) [Option 1: [15-75%] of Your Pre-disability Earnings/an amount you elect in increments of [\$1-\$100];]
- 2) [Option 2: [15-75%] of Your Pre-disability Earnings/an amount you elect in increments of [\$1-\$100]]]; or]
- 3) [[0-\$7500].]

[Reduced by other income benefits.]]

[Weekly Benefit: The lesser of:

- 1) [An amount You elect in increments of [\$1-\$100]];
- 2) [[15-75%] of your Pre-disability Earnings]]]; or]
- 3) [[0-\$7500]]

[reduced by Other Income Benefits.]]

[The Weekly Benefit will be rounded to the next higher \$10.00/\$1.00 if not already such a multiple.]

[Minimum Weekly Benefit: [\$0-25]]

[The **Maximum Duration of Benefits** for a Disability is:

- 1) [if Your Disability is the result of a Pre-existing Condition: [4 weeks] if caused by Injury or Sickness]]]; otherwise]
- 2) [[13,26,52] weeks if caused by Injury]]]; or]
- 3) [[13,26,52] weeks if caused by Sickness.]]

[Benefits Commence:

- 1) [for Disability caused by Injury: on the [1st -15th] consecutive day of Total Disability or Disabled and Working;
- 2) for Disability caused by Sickness: on the [1st-15th]consecutive day of Total Disability or Disabled and Working
- 3) with the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program.

For hospital confinements of 24 hours or more, benefits commence on the first day of hospital confinement.]]

[Annual Enrollment Period: From month & day through month & day]

[Eligibility Waiting Period for Coverage

Schedule of Insurance

- 1) [0-90] [[days][weeks][months] - if You are Actively at Work for the Employer on the Policy Effective Date; or
- 2) [0-90] [[days][weeks][months] - if You start working for the Employer after the Policy Effective Date.

The number of days referenced above is continuous calendar days. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a [Full-time][Part-time][temporary] Active Employee with the Employer under the Prior Policy.]]

Definitions

[Actively at Work] means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

- 1) in the usual way; and
- 2) for [Your usual number of hours.]

[We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.]

[Active [Employee]] means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.]]

[Any Occupation] means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of:

- 1) [the product of Your Indexed Pre-disability Earnings and the Initial Benefit Period Percentage]; or
- 2) [the Maximum Weekly Benefit.]]

[Bonuses] means the [weekly average of monetary] bonuses You received from [the Employer] [over:

- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
- 2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]]]

[Commissions] means the [weekly average of monetary] commissions You received from [the Employer] [over:

- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
- 2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]]

[Current [Monthly/Weekly] Earnings] means [Monthly/Weekly] earnings You receive from:

- 1) [the Employer; and
- 2) other employment;]

while You are Disabled [and eligible for the Disabled and Working Benefit.]

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly/Weekly] Earnings.]

[Current [Monthly/Weekly] Earnings also includes the pay You could have received for another job or a modified job if:

- 1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
- 2) the requirements of the position were consistent with:
 - a) Your education, training and experience; and
 - b) Your capabilities as medically substantiated by Your Physician.]]

Definitions

[Disabled and Working]

means that You [or Your Spouse] are prevented by:

- 1) Injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) [pregnancy]

from performing some, but not all of the Essential Duties of Your [or his or her] Occupation, are working on a part-time or limited duty basis [before age 70] [and, as a result, Your [or Your Spouse's] Current [Weekly] Earnings are more than [20] %, but are less than or equal to [80]% of Your [or Your Spouse's] Pre-disability Earnings.]]

[Disability or Disabled]

means Total Disability [or Disabled and Working Disability].]

[Employer]

means the [Participating Employer].]

[Essential Duty]

means a duty that:

- 1) is substantial, not incidental;
- 2) is fundamental or inherent to the occupation; and
- 3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.]]

[Injury]

means bodily injury resulting:

- 1) directly from accident; and
- 2) independently of all other causes;

[which occurs while You are covered under The Policy.] [However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.]]

[Mental Illness]

means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

Mental Retardation;

- 1) Pervasive Developmental Disorders;
- 2) Motor Skills Disorder;
- 3) Substance-Related Disorders;
- 4) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- 5) Narcolepsy and Sleep Disorders related to a General Medical Condition.]

[Other Income Benefits

Definitions

means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuant to any:

- 1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
- 2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
- 3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the result of membership in or association with any group, association, union or other organization;
- 4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
- 5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
- 6) [mandatory "no-fault" automobile insurance plan;]
- 7) disability benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act;that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or
- 8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
 - a) that begins after You become Disabled; or
 - b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

- 1) disability benefit under the Employer's Retirement plan;
- 2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
- 3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
- 4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
 - a) You were receiving it prior to becoming Disabled; or
 - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;(Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or
- 5) retirement benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
 - d) similar plan or act;that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

Definitions

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

- 1) the amount attributed to loss of income; and
- 2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- 1) takes effect after the date benefits become payable under The Policy; and
- 2) is a general increase which applies to all persons who are entitled to such benefits.]

[Participating Employer]

means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.]

[Physician]

means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art who treats patients on a regular basis, that We recognize or are required by law to recognize;
- 2) licensed to practice and prescribe and administer drugs or to perform surgery in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You [or your business partner] or Related to You by blood, marriage or adoption.]

[Pre-disability Earnings]

means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]:

- 1) the [weekly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for:
 - a) the [X tax] year(s) just prior to the date of Disability; or
 - b) the number of months You were employed in this capacity, if less than above period; and
- 2) [not] contributions You make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non-qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan, for the same period as above.

Pre-disability Earnings [does not include] [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital.]

[Pre-disability Earnings]

means, [for specific class description if applicable] Your average [weekly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period:

- 1) [not] including contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and
- 2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense

Definitions

reimbursements for the same period as above.]

[Pre-disability Earnings

means, [for specific class description if applicable] Your contracted [annual] rate of pay from Your Employer [plus income from your participation in other school related, extra-curricular activities,] divided by [52 weeks.]

Pre-disability Earnings shall:

- 1) [not] include contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and shall
- 3) [not] include income received from:
 - a) bonuses;
 - b) commissions;
 - c) overtime pay;
 - d) wages for extra-curricular school activities or programs;
 - e) Your employer's contribution on Your behalf to a retirement Plan or deferred compensation arrangement.]

[If we determine your earnings vary substantially from week to week, we may determine Your rate of pay by averaging Your earnings over the most recent [13] weeks.]]

[Prior Policy

means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date.]

[Regular Care of a Physician

means that You are being treated by a Physician:

- 1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
- 2) whose treatment is:
 - a) consistent with the diagnosis of the disabling condition;
 - b) according to guidelines established by medical, research, and rehabilitative organizations; and
 - c) administered as often as needed;

to achieve the maximum medical improvement.]

[Rehabilitative Employment

means employment or service which:

- 1) prepares a Disabled person to resume gainful work; and
- 2) is approved, in writing, by Us.]

[Related

means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].]

[Retirement Plan

means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

- 1) [a profit sharing plan;
- 2) thrift, savings or stock ownership plans;
- 3) a non-qualified deferred compensation plan; or
- 4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.]

Definitions

- [Sickness]** means a Disability [or loss] which is:
- 1) caused or contributed to by:
 - a) any condition, illness, disease or disorder of the body;
 - b) any infection, except a pus-forming infection of an accidental cut or wound [or bacterial infection resulting from an accidental ingestion of a contaminated substance];
 - c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or
 - d) [pregnancy;] or
 - 2) caused or contributed to by any medical [or surgical] treatment for a condition shown in item 1) above.]
- [Substance Abuse]** means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
- 1) impairments in social and/or occupational functioning;
 - 2) debilitating physical condition;
 - 3) inability to abstain from or reduce consumption of the substance; or
 - 4) the need for daily substance use to maintain adequate functioning.
- [Substance includes alcohol and drugs but excludes tobacco and caffeine.]]
- [The Policy]** means the policy which We issued to [The Policyholder under the policy number] shown on the face page.]
- [Tips [and Tokens]]** means the [weekly average of monetary] tips and tokens You received from [the Employer] [over:
- 1) the [X month] period ending [immediately prior to the date] You became Disabled; or
 - 2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]]
- [Total Disability or Totally Disabled]** means that You are prevented by:
- 1) Injury;
 - 2) Sickness;
 - 3) Mental Illness;
 - 4) Substance Abuse; or
 - 5) [pregnancy;]
- from performing the Essential Duties of Your Occupation,[and as a result, You are earning 20% or less of Your Pre-Disability Earnings.]]
- [Trust]** means [the trust fund established by Kanawha Insurance Company.]]
- [We, Our, or Us]** means [the insurance company named on the face page of The Policy.]]
- [Weekly] Benefit** means a [weekly] sum payable to You while You are Disabled, subject to the terms of The Policy. [Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.]
- [Your Occupation]** means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.
- [If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.]

Definitions

[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]

[You or Your means the person to whom this certificate is issued.]

Eligibility and Enrollment

[Eligible Persons: Who is Eligible for Coverage? All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.]

[Eligibility for Coverage: When will I become Eligible? You will become eligible for coverage on the later of:
1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage.
See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]

[Enrollment: How do I enroll for coverage? [For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll.] To enroll [for coverage] You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:]

- 1) You must give Us Evidence of Insurability satisfactory to Us; and
- 2) [You may only enroll:
 - a) during an [Annual Enrollment Period] designated by the Policyholder; or
 - b) within [31 days] of the date You have a Change in Family Status.]

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]]

[Evidence of Insurability: What is Evidence of Insurability? Evidence of Insurability may include, but will not be limited to:
1) [a completed and signed application approved by Us;
2) a medical examination; and
3) any additional information and attending Physicians' statements.]

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.]

[Change in Family Status: What constitutes a Change in Family Status? A Change in Family Status means:
1) [You get married or You execute a domestic partner affidavit;
2) Your child is born or You adopt or become the legal guardian of a child;
3) Your spouse dies or You and Your spouse divorce;
4) Your child is emancipated or dies;
5) Your spouse is no longer employed, which results in a loss of group insurance; or
6) You have a change in classification from part-time to full-time or from full-time to part-time.]]

Period of Coverage

[Effective Date:
*When does my
coverage start?*

[If You are not required to contribute toward The Policy's cost,] Your coverage will start:

- 1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or
- 2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.]

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:

- 1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then;
- 2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible;
- 3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or]
- 4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.]]

**[Deferred
Effective Date:**
*Will my coverage
start or an increase
in my coverage
take effect if I am
not Actively at
Work on the date
my coverage is to
start or increase?*

If You are absent from work due to:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) [pregnancy;]

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day.]

Period of Coverage

[Changes in Coverage: Can I change my benefit option?

[You may change Your benefit option only:

- 1) during an Annual Enrollment Period; or
- 2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

- 1) [the first day of the month following the Annual Enrollment Period;] or
- 2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:

- 1) the date You enroll for the change; or
- 2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:

- 1) Deferred Effective Date; and
- 2) Pre-existing Conditions Limitations.]]

[Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

- 1) are an Active Employee; and
- 2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.]

[What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:

- 1) the Deferred Effective Date provision; and
- 2) Pre-existing Conditions Limitations.]

Period of Coverage

[Continuity From A Prior Policy: Is there continuity of coverage from a Prior Policy?

[If You were:

- 1) insured under the Prior Policy; and
 - 2) not eligible to receive benefits under the Prior Policy;
- on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]]

[Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

- 1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
- 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Weekly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

- 1) the [Weekly] Benefit which was paid by the Prior Policy; or
- 2) the [Weekly] Benefit provided by The Policy.]

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]]

[Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [weekly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] of Your return to work:

- 1) You have a recurrence of the same disability while covered under The Policy; and
 - 2) there are no benefits available for the recurrence under the Prior Policy;
- the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.]

Period of Coverage

Termination:

When will my coverage stop?

Your coverage will end on the earliest of the following:

- 1) [the date] The Policy terminates;
- 2) [[the date] The Policy no longer insures Your class;]
- 3) [the date] premium payment is due but not paid by the Employer;
- 4) [the last day of the period for which You make any required premium contribution;]
- 5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;]
- 6) [the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason, unless coverage is extended under the Continuation Provisions; or
- 7) [the date Your Employer ceases to be a Participating Employer].

Period of Coverage

[Continuation Provisions: Can my insurance be continued?]

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.

Continued coverage:

- 1) is subject to any reductions in the Policy;
- 2) is subject to payment of premium [by the Employer;] and
- 3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.]

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.]

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.]

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.]

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]]

[Coverage while Disabled: Does my insurance continue while I am Disabled and no longer an Active Employee?]

[If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

- 1) while You remain Disabled; and
- 2) until the end of the period for which You are entitled to receive [short term] Disability Benefits provided premiums for Your coverage continue to be paid.

After [short term] Disability benefit payments have ceased, Your insurance will be reinstated, provided:

- 1) You return to work for one full day as a [Full-time] Active Employee in an eligible class;
- 2) The Policy remains in force; and
- 3) the premiums for You were paid during Your Disability, and continue to be paid.]]

Period of Coverage

[Extension of Benefits for Disability: Do my benefits continue if the Policy terminates?

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

- 1) will continue as long as You remain Disabled by the same Disability; but
- 2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.]

Benefits

[Disability Benefit: *When do I qualify for Disability Benefits?*

If, while covered under this Benefit, You:

- 1) become Totally Disabled;
- 2) remain Totally Disabled; and
- 3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

[The amount of any Weekly Benefit payable will be reduced by:

- 1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
- 2) any income received from [the Employer] for the period You are Totally Disabled.]]

[Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*

Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.]

[Partial Week Payment: *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay [1/7] of the Weekly Benefit for each day You were Disabled.]

Benefits

[Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*

When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

- 1) due to the same cause; or
- 2) due to a related cause; and
- 3) within [14] consecutive [calendar] days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [14] consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.]

[Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

- 1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
- 2) any Exclusions [and Pre-existing Conditions Limitations] will apply to the new cause of Disability.]

Benefits

[Termination of Benefit

Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]]
- 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
- 5) the date of Your death;
- 6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;]
- 7) [the last day benefits are payable according to the Maximum Duration of Benefits;
- 8) [the date Your Current Monthly/Weekly Earnings are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;] or
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;] or
- 10) [the date You refuse to participate in a Rehabilitation program, [or refuse to cooperate with or try:
 - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;]
 - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;]]] or
- 11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
 - a) You were receiving them prior to becoming Disabled; or
 - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

Benefits

[Disabled and Working Benefits: How

are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, [We will use the following calculation to determine Your [or Your Spouse's] [Weekly/Monthly] Benefit:

$$\text{[Weekly/Monthly] Benefit} = (A - B) \times C$$

A

Where

A = Your Pre-disability [Weekly/Monthly] Earnings.

B = Your Current [Weekly/Monthly] Earnings.

C = The [Weekly/Monthly Benefit] payable if You were Totally Disabled.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.]]

[Disabled and Working Benefits: How

are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, [the Weekly/Monthly Benefit] otherwise payable for Total Disability will be reduced by [%] of Your Current [Weekly/Monthly] Earnings. Your [Weekly/Monthly Benefit], however, will not be less [than the Minimum Weekly/Monthly Benefit.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.]]

[Disabled and Working Benefits: How

are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, [and payments under the Total Disability benefit under The Policy have begun, the following calculation will be used to determine Your [Weekly/Monthly Benefit]:

- 1) multiply Your Pre-Disability Earnings by the Benefit Percentage; and
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount deduct Other Income Benefits.

Current Weekly/Monthly Earnings will not be used to reduce Your [Weekly/Monthly] Benefit. However, if the sum of Your Weekly/Monthly Benefit and Your Current [Weekly/Monthly] Earnings exceeds [80% of] Your Pre-Disability Earnings, We will reduce Your [Weekly/Monthly] Benefit by the amount of the excess.]

If You are participating in a program of Rehabilitative Employment approved by us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence/Elimination Period.]]

Benefits

**[Rehabilitative
Employment
Benefit: What
happens to my
benefits if I
accept
Rehabilitative
Employment?**

If, while You are Totally Disabled [or Disabled and Working], You accept Rehabilitative Employment, We will continue to pay a [Weekly/Monthly] Benefit.

The [Weekly/Monthly] Benefit We will pay will be equal to Your Total Disability [Weekly/Monthly] Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the [Weekly/Monthly] Benefit and total income received from Rehabilitative Employment may not exceed [100%] of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the [Weekly/Monthly] Benefit paid by Us will be reduced by the excess amount.

We reserve the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Policy.

If You remain Totally Disabled [or Disabled and Working] after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit [or Disabled and Working], subject to the Maximum Payment Period for such benefit.]

Benefits

OPTIONAL

[Cost-Of-Living Adjustment:

How do my benefits keep pace with inflation?

We [will] adjust Your Weekly Benefit for increases in the cost-of-living if:

- 1) You have been Disabled for [12 consecutive months]; and
- 2) [You are receiving benefits;] [and
- 3) Your Current Weekly Earnings are less than or equal to 20% of Your Pre-disability Earnings;]

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.]

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

- 1) determining the lesser of:
 - a) [%]; or
 - b) [1/2] the percentage change in the Consumer Price Index;
- 2) multiplying the resulting percentage (%) times the Weekly Benefit for Disability being received; and
- 3) adding the resulting amount to Your Weekly Benefit.

When will the Cost-of-Living Adjustments end?

You will not receive a Cost-of-Living Adjustment after:

- 1) You cease to be Disabled; [or
- 2) You have received [5] adjustments;] or
- 3) The Policy terminates.

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered].

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.]

Benefits

**[Cafeteria Plan
Election
Restriction**

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:

The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.]

Exclusions and Limitations

[Exclusions:
*What Disabilities
are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability:

- 1) unless You are under the Regular Care of a Physician;
- 2) that is caused [or contributed to by] war or act of war (declared or not);
- 3) caused by Your commission of or attempt to commit a felony;
- 4) caused or contributed to by Your being engaged in an illegal occupation;
- 5) caused [or contributed to by] an intentionally self-inflicted [Injury];
- 6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer;
- 7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
- 8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

- 1) was sponsored by the Employer; and
- 2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]]

**[Pre-Existing
Condition
Limitation:** *Are
benefits limited
for Pre-existing
Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You become Disabled:

- 1) You have not received Medical Care for the condition for [365] consecutive day(s) while insured under The Policy; or
- 2) [You have been continuously insured under The Policy for [365] consecutive day(s)].

Pre-existing Condition means:

- 1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or
- 2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the [180] day period that ends the day before:

- 1) Your effective date of coverage; or
- 2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

- 1) is consulted or gives medical advice; or
- 2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

- 1) medical examinations, tests, attendance or observation; and
- 2) use of drugs, medicines, medical services, supplies or equipment.]

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.]

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim.

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.]

Proof of Loss: *What is Proof of Loss?*

[Proof of Loss may include but is not limited to the following:

- 1) documentation of:
 - a) the date Your Disability began;
 - b) the cause of Your Disability;
 - c) the prognosis of Your Disability;
 - d) Your Pre-disability Earnings, Current [Monthly/Weekly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
 - e) evidence that You are under the Regular Care of a Physician;
- 2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 3) the names and addresses of all:
 - a) Physicians or other qualified medical professionals You have consulted;
 - b) hospitals or other medical facilities in which You have been treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;
- 4) Your signed authorization for Us to obtain and release:
 - a) medical, employment and financial information; and
 - b) any other information We may reasonably require;
- 5) Your signed statement identifying all Other Income Benefits; and
- 6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.] All proof submitted must be satisfactory to Us.

[Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

- 1) meet and interview with our representative; and
- 2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

- 1) at Our expense; and
- 2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.]

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible; but
- 3) not later than [1 year] after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request.

General Provisions

Claim

Payment: *When are benefit payments issued?*

When We determine that You;

- 1) are Disabled; and
- 2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as] Proof of Loss satisfactory to Us is received.

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be

Paid: *To whom will benefits for my claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent;

then We may pay up to [\$1,000] to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial:

What notification will I receive if my claim is denied?

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the Policy provisions on which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

Claim Appeal:

What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

- 1) You must request a review upon written application within:
 - a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) You may request copies of all documents, records, and other information relevant to Your claim; and
- 3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

General Provisions

[Social Security: When must I apply for Social Security Benefits?

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

- 1) to follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

[Benefit Estimates: How does the Company estimate Disability benefits under the United States Social Security Act?

We reserve the right to reduce Your [Monthly/Weekly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly/Weekly] Benefit by the estimated amount. Your [Monthly/Weekly] Benefit will not be reduced by estimated Social Security disability benefits if:

- 1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
- 2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
- 3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly/Weekly] Benefit by an estimated amount and:

- 1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly/Weekly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
- 2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly/Weekly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly/Weekly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.]

Overpayment: When does an overpayment occur?

An overpayment occurs:

- 1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
- 2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- 1) [retroactive awards received from sources listed in the Other Income Benefits definition;
- 2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
- 3) misstatement;
- 4) fraud; or
- 5) any error We may make.]

General Provisions

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.]

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
 - a) [You;
 - b) any other organization;
 - c) any other insurance company;
 - d) any other person to or for whom payment was made; and
 - e) Your estate.]
 - 2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly/Weekly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered;
 - 3) refer Your unpaid balance to a collection agency; and
- pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You:

- 1) suffer a Disability because of the act or omission of a Third Party;
- 2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
- 3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Reimbursement: *What are the Company's Reimbursement Rights?*

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

- a) a legal judgment;
- b) an arbitration award; or
- c) a settlement or otherwise;

You must reimburse Us for the lesser of:

- a) the amount of payment made or required to be made by Us; or
- the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than [60 days] after the date proof of loss is given; or
- 2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud.

General Provisions

Misstatements:

What happens if facts are misstated?

If material facts about You were not stated accurately:

- 1) Your premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.]

Policy

Interpretation:

Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

You must complete this form if you have requested insurance coverage for yourself and are required to provide evidence of insurability.

Instructions

[Employer's] Responsibility:

1. Fill out the [Employer] Section completely. Please note an incomplete form will result in a delay in processing the [Employee's] request for insurance. Refer to your Policy and [employee] records. These records are your property and are not on file with [Kanawha Insurance Company] Underwriting Department.
2. In Section # 1, "Who Requires an Application," indicate with a check mark why evidence of insurability is required for the [Employee]. See definitions in #3 below. Consult your Policy for all requirements, limitations, and exceptions.
3. In Section #2, "Coverage Summary," complete all coverage amounts for the [Employee]. Consult your [employee] records to determine current coverage amounts. Please note that [Kanawha Insurance Company] does not have access to [employee] records for amounts of coverage already in force.

Definitions of coverage requests:

- **Over Guaranteed Issue (GI) Limit:** Election of coverage exceeding the guaranteed issue amount (according to your Policy) for which evidence of insurability is required.
 - **Opting up to Higher Level of Coverage:** Election of additional increment(s) of coverage with insurance currently in force.
 - **Late Entrant:** [Employee] who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.
4. After completing the [Employer] Section on Page 2, forward the entire form to the employee.
 5. No premiums may be deducted on additional amounts requiring evidence of insurability until a final decision regarding coverage is received from [Kanawha Insurance Company] Underwriting Department.

[Employee's] Responsibility:

1. Make sure your [Employer] has already completed the [Employer] Section of this form in full.
2. Answer all questions completely and accurately. Even details like Height and Weight are very important and must be accurate. **Leaving information blank can result in delays or may result in your file being closed.**
3. YOU, THE [EMPLOYEE], MUST SIGN THIS FORM ON PAGES SIX AND SEVEN. Use your full legal signature and enter the date signed.
4. **BOTH THE [EMPLOYER] AND [EMPLOYEE] SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY [KANAWHA INSURANCE COMPANY] WITHIN 30 DAYS OF THE SIGNATURE DATE.**
5. You are required to notify [Kanawha Insurance Company] in writing of any changes in your medical condition to the best of your knowledge, between the date you sign this form and the date the coverage is approved.

[Employee's] Responsibility Continued:

Upon Completion
Send both the [Employer] and [Employee] Sections of this form to:
[Underwriting]
[Kanawha Insurance Company]
[Post Office Box 7777]
Lancaster SC 29721-7777]

TO BE COMPLETED BY [EMPLOYER] USING BLACK ONLY.

[Employer] Name											
H U M A N A											
Division (if applicable):								Policy Number			
								1 2 3 4 5 6 7 8 9 0			
Street Address											
1 2 3 M A I N S T R E E T											
City						State		ZIP			
L A N C A S T E R						S C		2 9 7 2 0			
Benefit Contact First Name				Benefit Contact Last Name				Benefit Contact Phone			
J O H N				D O E				8 0 3 / 2 8 5 / 1 2 3 4			
[Employee] First Name:						MI		Last Name			
J O H N								D O E			
Date of Hire (MM/DD/YYYY)				Family Status Change Date (MM/DD/YYYY)				Social Security Number			
0 3 / 0 3 / 1 9 9 9				0 3 / 0 3 / 2 0 1 0				1 2 3 / 4 5 / 6 7 8 9			
Base Annual Earnings				Earnings Increase Amount				Effective Date of Increase (MM/DD/YYYY)			
\$, 5 0 0				\$, 5 0 0				0 3 / 0 3 / 2 0 1 0			

1. Who Requires an Application: Refer to "**Definitions of Coverage**" in Item #3 on the Instructions page. Select the appropriate box for coverage type.

[Employee] Over Guaranteed Issue Limit Opting up to Higher Level of Coverage Late Entrant

2. Coverage Summary: Complete all three columns for the [Employee].

[Employee] Coverage	Basic (i.e. GI coverage if eligible or any existing coverage prior to this enrollment)	Supplemental (Amount to be medically underwritten)	Total Coverage (Combination of Current coverage and additional amount requested)
<input checked="" type="checkbox"/> Long Term Disability Class: 1 2 3	\$, 5 0 0 Monthly	\$, 5 0 0 Monthly	\$, 5 0 0 Monthly
<input checked="" type="checkbox"/> Short Term Disability Class: 1 2 3	\$, 5 0 0 Weekly	\$, 5 0 0 Weekly	\$, 5 0 0 Weekly

This is critical information and if left blank will cause a delay in processing your insurance request.

[Employee] First Name MI Last Name
 J O H N T A Y L O R

Street Address (include Apt., Suite or Floor):
 1 2 3 M A I N S T R E E T

City Day Time Phone
 L A N C A S T E R 8 0 3 / 2 8 5 / 1 2 3 4

State ZIP Social Security Number Evening Phone
 S C 2 9 7 2 0 1 2 3 / 4 5 / 6 7 8 9 8 0 3 / 2 8 5 / 1 2 3 4

Email Address
 J O H N D O E @ A N Y W H E R E . C O M

Occupation Birthdate (MM/DD/YYYY) Gender
 M A N A G E R 0 3 / 0 3 / 1 9 5 0 Male
 Female

Height Weight
 0 6 ft. 0 4 in. (required) 1 7 5 lbs. (required)

Health Questions (Please answer questions 1-24. If additional space is required, please attach a separate sheet. Sign and date each sheet.) Residents of: Florida, Indiana, Maine, Minnesota, North Carolina, Vermont, and Wisconsin, please see Variable Question Language on page 9 of the application for amended or added Language to the below questions. After you have read that information, answer the questions below.

For questions 1-6, during the past 10 years, have you: (Residents of: Indiana, Kansas, Maryland, and Minnesota, please provide medical history during the past 5 years.)

1. Had any surgery or been told to have surgery?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
2. Been in a hospital or other institution for diagnosis or treatment?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
3. Had any injuries from a car accident or filed a Workers' Compensation Claim?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
4. Been declined for any life or disability insurance coverage?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
5. Consulted or been examined by any healthcare provider for anything other than normal physical exams with normal findings or acute illness such as cold, flu or sore throat?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
6. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No

*****For each "YES" answer, identify the question number and provide details requested*****

Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address:		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address:		

[EMPLOYEE] FIRST NAME: JOHN MI: _____ LAST NAME: DOE

For questions 7-24, during the past 10 years, have you at any time been treated or told you have a problem with any of the following:

(Residents of: Indiana and Maryland, please provide medical history during the past 5 years.)

7. Heart condition, chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, stroke, or blood, circulatory or vascular system?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
8. Cancer, tumors, leukemia, moles, melanoma or basal cell carcinoma?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
9. Diabetes, thyroid, liver, hepatitis, glands or spleen?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
10. Asthma, bronchitis, pneumonia, respiratory problems or sleep apnea?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
11. Ulcers, stomach, colitis, rectum, intestines, gallbladder, or upper or lower digestive system?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
12. Arthritis or rheumatism?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
13. Kidneys, bladder or urinary tract?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
14. Genital or reproductive organ?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No

*****For each "YES" answer, identify the question number and provide details requested*****

Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		

[EMPLOYEE] FIRST NAME: JOHN MI: _____ LAST NAME: DOE

15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Indicate amount used daily: _____		
16. Eyes, ears, nose or throat?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
17. Psychiatric, mental or nervous disorders, including depression and anxiety?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
18. Back, neck, spine, bones or joints?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
19. Immune system, anemia or other blood conditions?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
20. Brain or nervous system problems, or epilepsy?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
21. AIDS, AIDS-related complex, immune deficiency disorder or do you have enlarged lymph nodes or unexplained weight loss?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
22. Are you currently pregnant? If "Yes", what was your pre-pregnancy weight? _____ lbs.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
23. Are you currently taking medication for any condition or disease?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No
24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?.....	<input type="radio"/> Yes	<input checked="" type="radio"/> No

Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		
Question No.	Medical condition:	
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of medical condition:	
Any limitations or residuals: Yes/No	If "Yes" list any limitations or residuals:	
Physician's name and complete address :		

[Employee] Primary Care Physician Name & Address:

Notice: Applicant is required to notify [Kanawha Insurance Company] in writing of any changes in the Applicant's medical condition to the best of their knowledge, between the date the Applicant signs this form and date the coverage is approved.

I hereby certify that the above statements and answers are complete and true to the best of my knowledge and belief. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. This information may be used by [Kanawha Insurance Company] (for fully insured coverages) or my [employer]/administrator (for self-funded coverages) for plan administration purposes to decide if I am eligible for coverage.

✓ JOHN DOE
SIGNATURE OF [EMPLOYEE]
or Legal Representative/Relationship to [Employee]
(required)

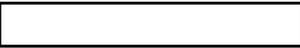
03 / 03 / 2010
DATE SIGNED

APPLICANT AUTHORIZATION: THIS SECTION IS VERY IMPORTANT. YOUR REQUEST CANNOT BE PROCESSED WITHOUT IT.

**Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Disability Income Coverage
(Group Disability Income is not subject to the requirements of HIPAA)**

I have applied for insurance under a Group Disability Policy issued by [Kanawha Insurance Company]. To assess whether I am eligible for this insurance, I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), effective April 14, 2003.

I **authorize** any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years (**Residents of Indiana** authorize within the last 5 years); insurance company; or reinsurance company, with which I have had coverage, and the Medical Information Bureau, Inc. (MIB), (collectively, "Releasers"); to disclose to [Kanawha Insurance Company], Health Information about me. [Kanawha Insurance Company] may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively ["Kanawha Insurance Company"]); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries, or any other health conditions, 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5) Counseling or therapy (**Residents of West Virginia**, reads as follows: Counseling or therapy, except that no adverse underwriting decision shall be made because I have demonstrated AIDS-related concerns or have sought AIDS-related counseling (this does not apply to my seeking treatment and/or diagnosis for Acquired Immune Deficiency Syndrome)). Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to [Kanawha Insurance Company]. [Kanawha Insurance Company] will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with [Kanawha Insurance Company].



By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization, and
- That I am authorizing the Releasers to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

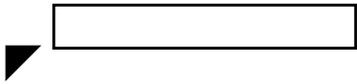
- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasers' knowledge. Note that [Kanawha Insurance Company] only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with [Kanawha Insurance Company]
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, [Kanawha Insurance Company] may not be able to process my application for coverage.
- That, if 1) [Kanawha Insurance Company] denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; [Kanawha Insurance Company] will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to [Kanawha Insurance Company] unless required by law.
- That, if necessary, [Kanawha Insurance Company] will send this Authorization to Releasers authorized to release health information about me.
- That [Kanawha Insurance Company] will also provide me with written notice of Releasers to which [Kanawha Insurance Company] sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasers. My revocation will not be effective: to the extent that action has been taken in reliance upon this Authorization; or, [Kanawha Insurance Company] otherwise has the right: to contest the Policy; or a claim under the Policy.

Residents of Virginia, review this additional text: Authorization signed for the purpose of collecting information in connection with an Application for an insurance Policy, a Policy reinstatement, or a request for change in Policy benefits remain valid no longer than 30 months from the date the Authorization is signed. Authorizations signed for the purpose of collecting information in connection with a claim for accident and sickness benefits under an insurance Policy remain valid for the entire term of the coverage of the Policy. Authorizations signed for the purpose of collecting information in connection with a claim for any other benefits under an insurance Policy remain valid for the duration of the claim.

- That this Authorization will expire 24 months from the effective date of my coverage or if no coverage has been issued, 24 months from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

✓ JOHN DOE
 SIGNATURE OF [EMPLOYEE]
 or Legal Representative/Relationship to [Employee]
 (required)

 03 / 03 / 2010
 DATE SIGNED



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Variable question language

Florida Residents:

Question 21: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Indiana Residents:

Question 24: Please list injury, birth defect, or congenital defect not mentioned above.

Maine Residents:

You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota Residents:

YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

Question 24: Please list any symptom, injury, birth defect, congenital defect, disease, or other disorder not mentioned above that has been diagnosed or treated by a medical practitioner.

North Carolina Residents:

Question 21: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont Residents:

Question 21: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Wisconsin Residents:

Question 6: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Disclosure Notice

I authorize [Kanawha Insurance Company] to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I may apply for Life or Health Insurance, or other persons or organizations, performing business or legal services in connection with this Application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself in connection with this Application.

I understand that if I request details about any medical record information collected about myself in connection with this Application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, [Kanawha Insurance Company] must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the Authorization on the Application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: [Underwriting, Kanawha Insurance Company, PO Box 7777, Lancaster SC 29721-7777].

[Kanawha Insurance Company] (Hereafter the "Company")

<input checked="" type="checkbox"/> Long Term Disability <input type="checkbox"/> Buy-Up _____%		<input checked="" type="checkbox"/> Short Term Disability <input type="checkbox"/> Buy-Up _____%	
Name of [Policyholder] JOHN DOE			Policy No. (if known)
Name of Eligible Person (Last, First, MI) JOHN DOE			Social Security No. 123-45-6789
Your Home Address (Street, City, State, ZIP) 123 MAIN STREET LANCASTER SC 29720		Home Telephone (803)285-1234	Date of Birth 04-16-1950
		Work Telephone (803)285-1234	Gender (Check one) Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>
Job Title MANAGER		Job Location LANCASTER	
Date of Hire 01-01-1999		Earnings Per Period \$ 500 / week	
No. Hours worked per week 40		Employment Status <input checked="" type="checkbox"/> Active <input type="checkbox"/> COBRA (Check one) <input type="checkbox"/> Retiree	

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

All statements in the Enrollment Form and other information provided to the Company for the purpose of underwriting insurance under the Policy will be deemed representations and not warranties.

I REPRESENT that the statements in this Enrollment Form and other information provided to the Company for the purpose of underwriting insurance under the Policy, are complete and true to the best of my knowledge and belief.

I UNDERSTAND THAT insurance under the Policy is effective when the requirements are met as stated in the Effective Date of Insurance provision of the Policy.

I authorize deduction be made from my wages and the total amount deducted for premium be remitted to [Kanawha Insurance Company].

Signature JOHN DOE
Applicant

04/16/2010
Date

FOR GROUP COVERAGE

INTERNAL USE ONLY Group Number:

1. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Full Legal business name HUMANA	Requested effective date 04/16/2010			
Corporate/Situs location street address (P.O. Box not allowed) 123 MAIN STREET	City LANCASTER	State SC	ZIP code 29720	County LANCASTER
Billing address (N/A if same as street address)	City	State	ZIP code	County
Type of business	<input checked="" type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Sole Proprietorship <input type="radio"/> Other (explain) _____			
Date company established 01/01/199	Federal Tax ID 123456789			
Nature of business/SIC code INSURANCE	Business Phone number (803)285-1234	Business fax number (803)285-1234		
Do you have more than one location? <input type="radio"/> YES <input checked="" type="radio"/> NO				
Administrative contact Name <u>JANE DOE</u>				
Phone number (803)285-1234	Fax number (803)285-1234	E-mail JANEDOE@ANYWHERE.COM		

2. ELIGIBILITY REQUIREMENTS

Number of employees on payroll 40. An eligible employee is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	STD Class 1	STD Class 2	LTD Class 1	LTD Class 2
Number of hours worked per week to be eligible (select between 20 and 40 hours)	40	40	40	40
Number of employees in probationary waiting period (do not included in the eligible count)	40	40	40	40
Total number of eligible employees	40	40	40	40

New/Rehire employee effective date provision: (On all plans, the employee termination date coincides with the effective date provision.) First of month following probationary waiting period Immediately following probationary waiting period

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a combined tax return? YES NO If yes, enter information below:

Company name

Total employees

Employees not actively at work

As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages if necessary)

Effective dates for changes in amounts of coverage

Increases/decreases due to change in class: ● Effective first day of month following date change ○ Other _____

Increases/decreases requested by employee: ● Effective first day of month following date requested ○ Other _____

Increases (with Evidence of Insurability) requested by employee: ● Effective first day of month following approval date
○ Other

Evidence of Insurability required if amount of Basic plus Buy-up Insurance applied for exceeds amounts below:

	Class 1	Class 2
Employee LTD	40	40
Employee STD	40	40

Special Requests:

○ Check box and attach signed additional sheet or letter if custom dating, face amounts, etc. are desired.

3. EMPLOYER CONTRIBUTION(S)

● Basic STD _50___% ● Buy-Up STD _50___% ● Basic LTD __50___% ● Buy-Up LTD _50___%

4. PRIOR/CURRENT CARRIER INFORMATION

	STD	LTD
Is this group transferring from another group carrier?	○ Yes ● No	○ Yes ● No
If "Yes", provide carrier name		
Proposed termination date		

5. SHORT TERM DISABILITY (group sizes 2+). Attach additional signed and dated sheets (form GN-52336) if necessary.

Name of Class 1	
Funding type	<input checked="" type="radio"/> Contributory <input type="radio"/> Non-contributory <input type="radio"/> Voluntary
Benefit schedule (select one)	<input checked="" type="radio"/> 50% <input type="radio"/> 60% <input type="radio"/> 66.67% <input type="radio"/> Other _____ <input type="radio"/> Flat amount \$ _____ <input type="radio"/> Incremental amount \$ _____
Weekly Benefit Minimum	\$ 40
Weekly Benefit Maximum	\$ 40
Duration Weeks	<input checked="" type="radio"/> 13 <input type="radio"/> 26 <input type="radio"/> 52 <input type="radio"/> Other _____
Elimination period (Accident/Sickness)	<input checked="" type="radio"/> 1/8 <input type="radio"/> 8/8 <input type="radio"/> 15/15 <input type="radio"/> 30/30 <input type="radio"/> Other _____
Pre-existing limitation	<input checked="" type="radio"/> None <input type="radio"/> 3/3/12 <input type="radio"/> Other _____
Waiting period: Current employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Waiting period: Rehired/New employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Rate Guarantee	<input checked="" type="radio"/> 1 Year <input type="radio"/> 2 Year
Name of Class 2	
Funding type	<input checked="" type="radio"/> Contributory <input type="radio"/> Non-contributory <input type="radio"/> Voluntary
Benefit schedule (select one)	<input checked="" type="radio"/> 50% <input type="radio"/> 60% <input type="radio"/> 66.67% <input type="radio"/> Other _____ <input type="radio"/> Flat amount \$ _____ <input type="radio"/> Incremental amount \$ _____
Weekly Benefit Minimum	\$ 40
Weekly benefit Maximum	\$ 40
Duration Weeks	Weeks: <input checked="" type="radio"/> 13 <input type="radio"/> 26 <input type="radio"/> 52 <input type="radio"/> Other
Elimination period (Accident/Sickness)	<input checked="" type="radio"/> 1/8 <input type="radio"/> 8/8 <input type="radio"/> 15/15 <input type="radio"/> 30/30 <input type="radio"/> Other _____
Pre-existing limitation	<input checked="" type="radio"/> None <input type="radio"/> 3/3/12
Waiting period: Current employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Waiting period: Rehired/New employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Rate Guarantee	<input checked="" type="radio"/> 1 Year <input type="radio"/> 2 Years

LONG TERM DISABILITY Attach additional signed and dated sheets (form GN-52336) if necessary.

Name of Class 1

Funding type	<input checked="" type="radio"/> Contributory <input type="radio"/> Non-contributory <input type="radio"/> Voluntary
Benefit schedule (select one)	<input checked="" type="radio"/> 50% <input type="radio"/> 60% <input type="radio"/> 66.67% <input type="radio"/> Other _____ <input type="radio"/> Incremental amount \$ _____
Monthly Benefit Minimum	<input checked="" type="radio"/> \$100 <input type="radio"/> 10% of monthly salary <input type="radio"/> Other _____
Monthly Benefit Maximum	\$ 40
Duration	<input checked="" type="radio"/> 2 Year <input type="radio"/> 5 Year <input type="radio"/> SSNRA <input type="radio"/> Other _____
Elimination period	Days: <input checked="" type="radio"/> 30 <input type="radio"/> 60 <input type="radio"/> 90 <input type="radio"/> 180 <input type="radio"/> Other _____
Definition of disability	Year own occupation: <input checked="" type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> to age 65 <input type="radio"/> Other _____
Pre-existing limitation	<input checked="" type="radio"/> 3/3/12 <input type="radio"/> 6/6/12 <input type="radio"/> 12/12/24 <input type="radio"/> 3/12 <input type="radio"/> 6/12 <input type="radio"/> 12/24 <input type="radio"/> Other _____
Mental health and substance abuse limitation	<input checked="" type="radio"/> 24 month Outpatient <input type="radio"/> 12 month Outpatient <input type="radio"/> Other _____
Waiting period: Current employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Waiting Period: Rehired/New employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Rate guarantee	<input checked="" type="radio"/> 1 Year <input type="radio"/> 2 Years <input type="radio"/> Other _____

Name of Class 2

Funding type	<input checked="" type="radio"/> Contributory <input type="radio"/> Non-contributory <input type="radio"/> Voluntary
Benefit schedule (select one)	<input checked="" type="radio"/> 50% <input type="radio"/> 60% <input type="radio"/> 66.67% <input type="radio"/> Other _____ <input type="radio"/> Incremental amount \$ _____
Monthly Benefit Minimum	<input checked="" type="radio"/> \$100 <input type="radio"/> 10% of monthly salary <input type="radio"/> Other _____
Monthly Benefit Maximum	\$ 40
Duration	<input checked="" type="radio"/> 2 Year <input type="radio"/> 5 Year <input type="radio"/> SSNRA <input type="radio"/> Other _____
Elimination period	Days: <input checked="" type="radio"/> 30 <input type="radio"/> 60 <input type="radio"/> 90 <input type="radio"/> 180 <input type="radio"/> Other _____
Definition of disability	Year own occupation: <input checked="" type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> to age 65 <input type="radio"/> Other _____
Pre-existing limitation	<input checked="" type="radio"/> 3/3/12 <input type="radio"/> 6/6/12 <input type="radio"/> 12/12/24 <input type="radio"/> 3/12 <input type="radio"/> 6/12 <input type="radio"/> 12/24 <input type="radio"/> Other _____
Mental health and substance abuse limitation	<input checked="" type="radio"/> 24 month Outpatient <input type="radio"/> 12 Month Outpatient <input type="radio"/> Other _____
Waiting period:	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Waiting Period: Rehired/New employees	<input checked="" type="radio"/> Eligible on date of employment <input type="radio"/> Eligible after active employment for _____ days
Rate guarantee	<input checked="" type="radio"/> 1 Year <input type="radio"/> 2 Years <input type="radio"/> Other _____

Additional benefits (for LTD only): Please refer to your proposal for additional benefits availability with plan selected.
 Attach additional signed and dated sheets (form GN-52336) if necessary

Cost of living adjustment (3%)	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, select : <input type="radio"/> Lesser of 3% or 1/2 CPI <input type="radio"/> Lesser of 6% or 1/2 CPI Number of Adjustments <input type="radio"/> 5 <input type="radio"/> 10
Activities of Daily Living	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, select additional Maximum Amount <input type="radio"/> 10% <input type="radio"/> 20% <input type="radio"/> 30% <input type="radio"/> 40%
Infectious & Contagious Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, Select: Waiting Period: <input type="radio"/> 6 months <input type="radio"/> 12 months Earnings Loss: <input type="radio"/> 20% <input type="radio"/> 40% Duration of Benefits: <input type="radio"/> 2 Years <input type="radio"/> 3 Years <input type="radio"/> 4 Years <input type="radio"/> Duration of Claim Benefits Cease if Earnings Exceed: <input type="radio"/> 80 % <input type="radio"/> 60 %
Accidental Dismemberment and Loss of Sight	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, Select: Loss Occurs within: <input type="radio"/> 90 Days <input type="radio"/> 180 Days <input type="radio"/> 365 Days
Business Income Protection	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, select: <input type="radio"/> 15% to \$2,500 <input type="radio"/> 25% to \$5,000
Pension Contribution	<input type="radio"/> Yes <input checked="" type="radio"/> No
Extended Earnings	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, Select: Qualification for Benefit: <input type="radio"/> Less than 60% of PDE <input type="radio"/> Less than 80% of PDE <input type="radio"/> Less than 100% of PDE Benefit End Date: The Lesser of <input type="radio"/> 12 <input type="radio"/> 24 <input type="radio"/> 6 <input type="radio"/> 3 months or when Earnings Exceed Qualification %
Medical Premium Supplemental	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, Select: Duration of Benefits: <input type="radio"/> 2 Years <input type="radio"/> 3 Years <input type="radio"/> 4 Years <input type="radio"/> 5 Years <input type="radio"/> Duration of Claim
Survivor Income Benefit	<input type="radio"/> Yes <input checked="" type="radio"/> No If Yes, select: <input type="radio"/> 3 month gross lump sum <input type="radio"/> 6 month gross lump sum

6. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS

The companies listed on this Master Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we make final decisions under the Policy or Certificate with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, we shall have full and exclusive discretionary authority to: (1) interpret Policy or Certificate provisions; (2) make decisions regarding eligibility for coverage and benefits; and (3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Certificate. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

Based upon our standard underwriting practice, we may require an employee to submit Evidence of insurability. We have the right to use the information provided by you and the applicant to determine whether coverage will be provided.

7. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, understand, agree and represent: You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed a proposal and the applicable regulatory information required by your state. Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. The first month's estimated premium must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the deposit check. You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate or the group's coverage. This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us. If this application is declined, we will return the premium deposit submitted with this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this Application, we will decline to issue the group policy.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: 04/16/2010 (month, date, year) at LANCASTER (city and state)

By: JANE DOE JANE DOE MANAGER
Authorized Representative Printed Name Authorized Representative Signature (Title)

AGENT/PRODUCER INFORMATION

Agency of Record (for commissions and correspondence)

Name (print or type) S/B LILLY KANAWHA

Tax ID/Social Security Number/Humana Agent Number 123456789

Commission split

If yes, percentage: 100 (total should equal 100%)

Agent/Agency of Record (for split commissions)

Name (print or type) _____

Tax ID/Social Security Number/Humana Agent Number _____

Commission split

If yes, percentage: _____ (total should equal 100%)

General Agency (complete only if agency involved in sale)

General agency information pertains to:

Name (print or type) _____

Tax ID/Social Security Number/Humana Agent Number _____

Address _____

City _____ State _____ ZIP code _____

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent's Signature: S/B LILLY KANAWHA Date: 04/16/2010

SERFF Tracking Number: HUMA-126757016 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 46448
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
 Product Name: 1695 Group Trust LTD STD
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification.pdf	Approved-Closed	10/25/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The Application is included under the Form Schedule tab.	Approved-Closed	10/25/2010

	Item Status:	Status Date:
Satisfied - Item: RI Approval Comments: Attachment: SERFF Approval Disposition for RI.pdf	Approved-Closed	10/25/2010

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME:

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
1695	40
1696	41
1697	44

Signed: *Donna Faulkenberry*
Name: Donna Faulkenberry
Title: Compliance Analyst

Date: 8/10/2010

Disposition for HUMA-126545484

[Close](#)

SERFF Tracking Number:	HUMA-126545484	State:	Rhode Island
Filing Company:	Kanawha Insurance Company	State Tracking Number:	
Company Tracking Number:			
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.005 Combined Short Term and Long Term
Product Name:	Group Trust LTD-STD		
Project Name:			

Disposition Date: 08/03/2010
 Implementation Date: 08/03/2010
 Status: Approved
 Comment:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program :	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Kanawha Insurance Company	%	%	\$		\$	%	%

Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	Actuarial Certification - Life & A&H		Yes
Supporting Document	Actuarial Memorandum - Life & A&H		Yes
Supporting Document	Premium Rate Sheets - Life & A&H		Yes
Supporting Document	Actuarial Memorandum - A&H Rate Revision Filing		Yes
Supporting Document	A&H Experience		Yes
Supporting Document	Exhibits - A&H		Yes
Supporting Document	Health Insurance Checklist		Yes
Supporting Document	Disability Income Insurance Checklist		Yes
Supporting Document	Trust Agreement		Yes
Form	1695, Policy/Contract/Fraternal Certificate, Trust Policy		Yes
Form	1696, Certificate, LTD Certificate		Yes
Form	1697, Certificate, STD Certificate		Yes
Form	GN-01490-WB 12/09, Application/Enrollment Form, Evidence of Insurability form		Yes
Form	RI-01493-WB 12/09 , Application/Enrollment Form, Enrollment form		Yes
Form	GN-01493-WB 12/09 , Application/Enrollment Form, Enrollment form		Yes
Form	RI-01698-WB 2/10 , Application/Enrollment Form, Master Application		Yes

<i>Form</i>	<i>GN-01698-WB 2/10 , Application/Enrollment Form, Master Application</i>	<i>Yes</i>
Rate	Actuarial Memorandum	Yes
<i>Rate</i>	<i>Actuarial Memorandum</i>	<i>Yes</i>
Rate	Rates	Yes
<i>Rate</i>	<i>Rates</i>	<i>Yes</i>
<i>Rate</i>	<i>Rates</i>	