

SERFF Tracking Number: HARP-126894538 State: Arkansas  
Filing Company: Pan-American Life Insurance Company State Tracking Number: 47277  
Company Tracking Number: PAL001  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: Group Disability Income  
Project Name/Number: /

## Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: Group Disability Income SERFF Tr Num: HARP-126894538 State: Arkansas  
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 47277  
Closed

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: PAL001 State Status: Approved-Closed  
Long Term

Filing Type: Form Reviewer(s): Rosalind Minor  
Disposition Date: 11/22/2010

Authors: Joann Alleano, Michelle  
Kunzman, Mary Bielucki

Date Submitted: 11/09/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association,  
Trust, Other

Filing Status Changed: 11/22/2010

Explanation for Other Group Market Type:  
Labor Union

State Status Changed: 11/22/2010

Deemer Date:

Created By: Mary Bielucki

Submitted By: Mary Bielucki

Corresponding Filing Tracking Number:

Filing Description:

Purpose

In our capacity as the Reinsurer and designated filing agent, we are submitting the enclosed forms on behalf of Pan American Life Insurance Company ("Pan American") for your review and approval.

This is a new filing and the forms present a program of group disability income insurance.

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### Submitted Material

The forms are in final printed form subject to changes in font style, margins, page numbers, order of forms, ink and paper stock. Pages are numbered before any options are selected and, therefore, the page numbers will roll accordingly. Printing standards will never be less than those required by law. Once approved, the Company reserves the right to use the forms in their approved format in a variety of media, including the internet, with the understanding that there may be slight accommodations for electronic viewing.

Flesch Test. The certificate has been tested for readability and achieves the following Flesch readability score: 40.0  
The policy has been tested as well and it achieves a Flesch readability score of 40.9.

Variability of Forms. The variable material is set off by brackets to be variable so that it may be added to, deleted from or changed.

If you have any questions or comments, please do not hesitate to contact me at (860) 843-6998 or mary.rupp@hartfordlife.com

## Company and Contact

### Filing Contact Information

Mary Rupp, mary.rupp@hartfordlife.com  
200 Hopmeadow Street 860-843-6998 [Phone]  
Simsbury, CT 06089

### Filing Company Information

(This filing was made by a third party - TheHartford03)

Pan-American Life Insurance Company	CoCode: 67539	State of Domicile: Louisiana
601 Poydras	Group Code:	Company Type:
New Orleans, LA 70130	Group Name:	State ID Number:
(860) 843-6998 ext. [Phone]	FEIN Number: 72-0281240	

## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? Yes  
Fee Explanation: \$50 per form for Policy, Certificate and Application.

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$150.00	11/09/2010	41693934

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/22/2010	11/22/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/18/2010	11/18/2010	Mary Bielucki	11/22/2010	11/22/2010

*SERFF Tracking Number:* HARP-126894538      *State:* Arkansas  
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*Company Tracking Number:* PAL001  
*TOI:* H11G Group Health - Disability Income      *Sub-TOI:* H11G.005 Combined Short Term and Long Term  
*Product Name:* Group Disability Income  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 11/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Third Party Filing Authorization	Approved-Closed	Yes
<b>Form</b>	Policy of Incorporation	Approved-Closed	Yes
<b>Form</b>	Certificate	Approved-Closed	Yes
<b>Form (revised)</b>	Group Application	Approved-Closed	Yes
<b>Form</b>	Group Application	Replaced	Yes

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Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/18/2010

Submitted Date 11/18/2010

Respond By Date

Dear Mary Rupp,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Application, PAL-DI-10-APP (Form)

Comment:

The Fraud Warning for Arkansas should read: 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 increase is guilty of a crime and may be subject to fines and confinement in prison. Refer to ACA 23-66-503.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 11/22/2010  
 Submitted Date 11/22/2010

Dear Rosalind Minor,

### Comments:

Thank you for your letter,

### Response 1

Comments: We have updated the Fraud Warning accordingly.

### Related Objection 1

Applies To:

- Group Application, PAL-DI-10-APP (Form)

Comment:

The Fraud Warning for Arkansas should read: 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 increase is guilty of a crime and may be subject to fines and confinement in prison. Refer to ACA 23-66-503.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Application	PAL-DI-10-APP		Application/Enrollment Form	Initial		40.800	Final LTD STD Master Application_AR.pdf

### Previous Version

<i>SERFF Tracking Number:</i>	<i>HARP-126894538</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47277</i>
<i>Company Tracking Number:</i>	<i>PAL001</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>Group Disability Income</i>		
<i>Project Name/Number:</i>	<i>/</i>		
<i>Group Application</i>	<i>PAL-DI-10-APP</i>	<i>Application/Enrollment Form</i>	<i>Initial 40.800</i>
			<i>Final LTD STD Master Application.pdf</i>

No Rate/Rule Schedule items changed.

We look forward to your continued review and approval of our filing.

Sincerely,

Joann Alleano, Mary Bielucki, Michelle Kunzman

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## Form Schedule

### Lead Form Number: PAL-DI-10-P

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/22/2010	PAL-DI-10-P	Policy/Cont ract/Fratern al Certificate	Policy of Incorporation	Initial		40.900	PALIC_ POI_AR.pdf
Approved-Closed 11/22/2010	PAL-DI-10-C-AR	Certificate	Certificate	Initial		40.000	PALIC_DI Certificate_A R.pdf
Approved-Closed 11/22/2010	PAL-DI-10-APP	Application/ Enrollment Form	Group Application	Initial		40.800	Final LTD STD Master Application_A R.pdf



Name of Policyholder: [ABC POLICYHOLDER] 1

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]

Pan American Life Insurance Company
601 Poydras, New Orleans, LA 70130
(A stock insurance company, herein called The Company)
will pay benefits according to the terms and conditions of The Policy.

Signed for the Company

[Handwritten signature of José S. Suquet]

[José S. Suquet ]
[Chairman of the Board]

2

[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. ] 3

Countersigned by.....
[Licensed Resident Agent or] Registrar 4

Table of Contents

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

## Schedule of Insurance

The Schedule(s) of Insurance for The Policy benefits listed below are shown in the Certificate(s), as incorporated into The Policy. **1**

- 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.] **2**

**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).] **1**

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: **2**

- 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**
- 2) [sex and occupational class.] **3**

[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.] **4**

The Initial Monthly Premium Rates may be converted as follows:

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

**Grace Period**

The Company will allow the Policyholder a [31] day grace period for the payment of all premiums after the first. During this [31] day period, The Policy will stay in force. If the owed premium is not paid by the [31st] 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. **5**

**[Monthly Premium Rate Guarantee**

Initial Monthly Premium rates are guaranteed as follows: **6**

<b>Benefit</b>	<b>Rate Guarantee Period</b>
[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: **7**

- 1) written notice is delivered to the Policyholder's last address on record; and **8**
- 2) the change is effective at least [31] days after the date of notice.] **8**

[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.] **9** **10**

## 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 **1**  
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

**2**

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

**3**

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 [ABC Policyholder.]

1

**Participating [Entity]** means any [Entity] that has [become a member of ABC Policyholder.]

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.]

2, 3

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]:

4

- 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.

5

**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.

6

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

7

- 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.]

8

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.

9

**Participating [Entities]**

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

]

## 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 issued in connection with such certificates;
- 4) the Policyholder's application, if any, a copy of which is attached to and made a part of The Policy when issued; and
- 5) any Personal Health 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 **1** 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.] **2**

**Changes:** The Company reserves the right to make changes in the Policy, [after The Policy has been in force for 12 months.] The **3** Company will give the Policyholder [31 days] advance written notice of any change. No agent has authority to change or waive **4** 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 **5,6** [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. **7**

### [Termination of Policy

The Company may terminate The Policy for the following reasons by giving the Policyholder [31] days written notice: **8,9**

- 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] **10**
- 4) [Less than 75% of the persons eligible for coverage on a Contributory Basis are insured.] **11**
- 5) [Fewer than 10 persons are insured.] **12**

In addition, The Company may terminate this policy on any premium due date after The Policy has been in force for [12 months] **13** by providing [31 days] written notice. **14**

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] **15**
- 2) [less than 75% of the persons eligible for Dependent Coverage on a Contributory Basis are insured.] **16**

The Company shall give the Policyholder [31 days] notice of its intent to terminate the Dependent Life Insurance Benefit.] **17**

## 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.

## Incorporation Provision

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.

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**RIDER:** This rider, issued [January 1, 2004], forms a part of Policy No. [XXXX] issued to **Policyholder**. It is effective [June 1, 2004]. It does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for **The Company**

  
[[ ]]

[José S. Suquet ]  
[Chairman of the Board]



## Policy Modifications

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Pan American Life Insurance Company
New Orleans, LA
(A stock insurance company)

[Policyholder: ABC Policyholder]
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE]
[Policy Anniversary Date: DATE]

1

[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

[Handwritten signature of José S. Suquet]

[José S. Suquet]
[Chairman of the Board]

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[READ YOUR CERTIFICATE CAREFULLY]

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.]

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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.** 1

**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 under Option 1.

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

### **Eligible Class(es) For Coverage:**

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

Full-time Employment:            at least # hours weekly

### **Weekly Benefit:** The lesser of:

- 1) Option 1: X% of Your Pre-disability Earnings;
- 2) Option 2: X% of Your Pre-disability Earnings; or
- 3) \$XX.

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

### **Minimum Weekly Benefit:** \$XXX

In accordance with Arkansas state law, in no event will the Minimum Weekly Benefit be less than \$12.50.

### **Maximum Duration of Benefits Payable:**

- 1) if Your Disability is the result of a Pre-existing Condition: # days if caused by Injury or Sickness; otherwise
- 2) # weeks if caused by Injury or Sickness

### **Benefits Commence:**

- 1) for Disability caused by Injury: on the 1<sup>st</sup> consecutive day of Total Disability or Disabled and Working;
- 2) for Disability caused by Sickness: on the 8<sup>th</sup> 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**

- 1) XX days - if You are Actively at Work for the Employer on the Policy Effective Date; or
- 2) XX days - if You start working for the Employer after the Policy Effective Date.

The number of days referenced above are 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.]

**Schedule of Insurance**

**[Participating Entity:**

**1**

<b>POLICYHOLDER:</b>	<b>CERTIFICATE NUMBER:</b>	<b>CERTIFICATE EFFECTIVE DATE:</b>
<b>POLICY NUMBER: XXXXXX</b>	<b>FIRST PREMIUM:</b>	<b>SCHEDULE EFFECTIVE DATE:</b>
<b>YOUR NAME</b>	<b>RENEWAL PREMIUM:</b>	<b>RENEWAL PREMIUM DUE DATE:</b>
	<b>POLICY AGE LIMIT:</b> 70 years of age	<b>RENEWAL PREMIUM PERIOD:</b>

**Premiums may change on any renewal date, and will always increase on the renewal date occurring on or next following the date a person covered under The Policy attains Ages 30, 35, 40, 45, 50, 55, 60, and 65.**

**Disability Benefit**

**Monthly Benefit: \$**

The Monthly Benefit payable will be subject to the Offset Provision shown below.

**Offset Provision:**

The benefit amount payable as the result of Your Total Disability will be the lesser of:

- 1) the Monthly Benefit; or
- 2) 60% of Your Pre-Disability Earnings minus:
  - a) any Other Income Benefits, including those for which You could collect but did not apply; and
  - b) all other income from any employer or for any work.

However, if Your Monthly Benefit would reduce to less than \$50.00 per month due to Other Income Benefits, then the minimum Monthly Benefit under The Policy will be \$50.00 per month.

**Maximum Payment Period:**

For Total Disability beginning:

- |                                 |         |
|---------------------------------|---------|
| 1) before age 61:               | 5 years |
| 2) age 61 or over but under 62: | 4 years |
| 3) age 62 or over but under 63: | 3 years |
| 4) age 63 or over but under 70: | 2 years |

The Monthly Benefit will be paid for the lesser of the period:

- 1) shown in the above table; or
- 2) to Your Normal Retirement Age under the most recent amendments to the United States Social Security Act.

However, the Maximum Payment Period may be reduced due to Mental Illness or Substance Abuse as specified in the Disability Benefit.

**Elimination Period:**

- Option 1: XX days  
 Option 2: XX days  
 Option 3: XX days

**Disabled and Working Benefit**  
**Maximum Payment Period:** See Benefit

**Minimum Indemnities for Specified Injuries**  
 See Benefit

**Rehabilitative Employment Benefit**  
 See Benefit]

**[Survivor Income Benefit**

**Benefit:** An amount equal to 3 times the last Monthly Benefit for Total Disability paid or payable to You.

**1**

**Schedule of Insurance**

**Monthly Benefit:** An amount equal to 75% of the last Monthly Benefit for Total Disability paid to You.

**Maximum Payment Period:** 12 months

**Hospital Income Benefit**

**Daily Benefit:** \$50-\$150 in \$50 increments

**Maximum Payment Period:** 365 days

**Cost of Living Adjustment Benefit**

See Benefit

**Business Overhead Expense Benefit**

**Monthly Benefit:**

**Reduction in Monthly Benefit Based on Age:**

On the premium due date on or next following the date You:

- a) attain age 60, if Your Monthly Benefit is greater than \$3,000.00, it will reduce to \$3,000.00; and
- b) attain age 65, if Your Monthly Benefit is greater than \$1,000.00, it will reduce to \$1,000.00;

with an appropriate adjustment in premium.

Any reduction in coverage will not apply to any period of continuous Total Disability that began prior to the effective date of the reduction.

**Guaranteed Issue Plan**

**Monthly Benefit:** \$500.00

**Maximum Payment Period:**

For Total Disability, as a result of an accident, beginning:

- 1) before age 61: 5 years
- 2) age 61 or over but under 62: 4 years
- 3) age 62 or over but under 63: 3 years
- 4) age 63 or over but under 70: 2 years

For Total Disability, as a result of a Sickness: 1 year

However, the Maximum Payment Period may be reduced due to Mental Illness or Substance Abuse as specified in the Disability Benefit.

**Elimination Period:** 90 days]

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. 1

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 under Option 1.
Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) for Coverage: All Full-time and Part-time Active Employees 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 # hours weekly
Part-time Employment: at least # hours weekly, but less than # hours weekly

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

Maximum Monthly Benefit: \$XXXXXXX

Guaranteed Issue Amount: \$XXXXXXX

Minimum Monthly Benefit: the greater of:

- 1) \$ # ; or
2) # % of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

In accordance with Arkansas state law, in no event will the Minimum Monthly Benefit be less than \$50.00.

Scheduled Monthly Benefit (Monthly Benefit): An amount you elect in increments of \$XXX

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

Benefit Percentage:

- Option 1: #%
Option 2: #%

Initial Benefit Period Percentage:

- Option 1: #%
Option 2: #%

Continuing Benefit Period Percentage:

- Option 1: #% of Pre-disability Earnings
Option 2: #% of Pre-disability Earnings

Eligibility Waiting Period for Coverage:

- Option 1: X days/weeks/months of continuous service
Option 2: X 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 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: X day(s)
Option 2: X day(s)

Maximum Duration of Benefits Table

Table with 2 columns: Age When Disabled, Benefits Payable. Rows include Prior to Age 62, Age 62.

### Schedule of Insurance

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]

## Definitions

<b>[Actively at Work]</b>	<p>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:</p> <ol style="list-style-type: none"> <li>1) in the usual way; and</li> <li>2) for [Your usual number of hours.]</li> </ol> <p>[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.]</p>	<p>1 2</p>
<b>[Actively at Work]</b>	<p><b>LTD/STD</b> means You are performing all the Essential Duties of Your Occupation for wage or profit [on a full-time basis (at least 30 hours per week).]</p>	1,2
<b>Active [Employee]</b>	<p><b>LTD (non-Employer Market)</b> 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.]</p>	1
<b>Activities of Daily Living (ADLs)</b>	<p><b>LTD/STD</b> means the following functions performed with or without equipment or adaptive devices:</p> <ol style="list-style-type: none"> <li>1) bathing Yourself by being able to either: <ol style="list-style-type: none"> <li>a) wash Yourself in a tub or shower devices; or</li> <li>b) give Yourself a sponge bath;</li> </ol> </li> <li>2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;</li> <li>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</li> <li>4) transferring from bed to chair or wheelchair; or</li> <li>5) bladder and bowel control by being able to either: <ol style="list-style-type: none"> <li>a) voluntarily control bowel and bladder function; or</li> <li>b) maintain a reasonable level of personal hygiene, if You are not so able; and</li> <li>c) feeding Yourself, once the food has been prepared and made available to You.</li> </ol> </li> </ol>	
<b>Age</b>	<p><b>LTD</b> means [Your attained age as of January 1 of each year.]</p>	1
<b>Any Occupation</b>	<p><b>LTD (non-Employer Market)</b> means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of:</p> <ol style="list-style-type: none"> <li>1) [the product of Your Indexed Pre-disability Earnings and the Initial Benefit Period Percentage]; or</li> <li>2) [the Maximum Monthly Benefit.]]</li> </ol>	<p>1 2 3</p>
<b>Bonuses</b>	<p><b>LTD/STD</b> means the [monthly average of monetary] bonuses You received from [the Employer] [over:</p> <ol style="list-style-type: none"> <li>1) the [X month] period ending [immediately prior to the date] You became Disabled; or</li> <li>2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]]</li> </ol>	<p>1, 2 3, 4 5</p>
<b>Commissions</b>	<p><b>LTD/STD</b> means the [monthly average of monetary] commissions You received from [the Employer] [over:</p> <ol style="list-style-type: none"> <li>1) the [X month] period ending [immediately prior to the date] You became Disabled; or</li> <li>2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]</li> </ol>	<p>1, 2 3, 4 5</p>
<b>Complications of Pregnancy</b>	<p><b>LTD/STD</b> [means a condition requiring hospital confinement whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:</p> <ol style="list-style-type: none"> <li>1) acute nephritis or nephrosis;</li> <li>2) cardiac decompensation;</li> <li>3) missed abortion; and</li> <li>4) similar medical and surgical conditions of comparable severity.</li> </ol> <p>Complications of Pregnancy will also include:</p> <ol style="list-style-type: none"> <li>1) pre-eclampsia;</li> <li>2) placenta previa;</li> <li>3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;</li> </ol>	1

**Definitions**

- 4) termination of ectopic pregnancy;
- 5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible; and
- 6) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:

- 1) elective Cesarean section;
- 2) false labor, occasional spotting, or morning sickness;
- 3) hyperemesis gravidarum; or
- 4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.] ]

**LTD (non-Employer Market)**

**[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 [or for increasing Your hours or duties to Your Maximum Capacity] if:

- 1) such job 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.]

**LTD/STD**

**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 [Monthly/Weekly] Earnings are more than [20]%, but are less than or equal to [80]% of Your [or Your Spouse's] Pre-disability Earnings.]

**STD**

**Definitions**

<b>Disability or Disabled</b>	means Total Disability [or Disabled and Working Disability].	1
	<b>STD</b>	
<b>Disability or Disabled</b>	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. ]	
	<b>LTD</b>	
<b>Disability or Disabled</b>	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 60%] of Your [Indexed] Pre-disability Earnings.	1 2 3 4
	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 60%] 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 60%] 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.]	5 6 7 8 9
	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.]	10 11
	<b>[Reasonable Alternative Job]</b> 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 60%] of Your [Indexed] Pre-disability Earnings.]	12 13,14
	<b>LTD</b>	

## Definitions

**Disability or Disabled**

means You are prevented from performing one or more of the Essential Duties of:	
1) Your Occupation during the Elimination Period;	1
2) Your Occupation, for the [24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 60%] of Your [Indexed] Pre-disability Earnings;	2,3
3) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] after that, [for the next 12 months]; and	4
4) after that, Any Occupation .	5
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 60%] 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 60%] 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.]	6 7 8 9 10
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.]	11 12
<b>[Reasonable Alternative Job]</b> 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 60%] of Your [Indexed] Pre-disability Earnings.]]	13 14, 15
<b>LTD</b>	

**Definitions**

<b>[Disability or Disabled]</b>	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;	1
	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 60%] of Your [Indexed] Pre-disability Earnings; and	2, 3 4, 5
	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 60%] 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 60%] 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.]	6 7 8 9 10
	 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.]	11 12
	 <b>[Reasonable Alternative Job]</b> 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 60%] of Your [Indexed] Pre-disability Earnings.]	13 14, 15
<b>Disability or Disabled</b>	<b>LTD</b> 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].	1 2 3 4
	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	5 6
	a) you have a Cognitive Impairment; or	
	b) you have a Terminal Illness.]	
<b>Disability or Disabled</b>	<b>LTD</b> 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;	1
	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	2,3 4,5
	 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 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.	6

## Definitions

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** **LTD** means the [longer of the] number of consecutive days at the beginning of any one period of [Total] 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]. 1,2  
3

**Employer** **LTD** means [the Policyholder]. 1

**Essential Duty** **LTD/STD** 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.] 1

**LTD/STD**

## Definitions

<b>[Indexed Pre-disability Earnings]</b>	<p>means Your Pre-disability Earnings adjusted annually by adding the lesser of:</p> <ol style="list-style-type: none"> <li>1) [10%;] or</li> <li>2) the percentage change in the Consumer Price Index (CPI-W).</li> </ol>	1
	<p>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.]</p>	2 3,4
	<p>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].</p>	5
<b>Injury</b>	<p><b>LTD</b> means bodily injury resulting:</p> <ol style="list-style-type: none"> <li>1) directly from accident; and</li> <li>2) independently of all other causes;</li> </ol> <p>[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.]</p>	1,2
<b>Maximum Capacity</b>	<p><b>LTD</b> means the full utilization of Your capabilities in Any Occupation</p>	
<b>Mental Illness</b>	<p><b>LTD</b> 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.</p> <p>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:</p> <ol style="list-style-type: none"> <li>1) Mental Retardation;</li> <li>2) Pervasive Developmental Disorders;</li> <li>3) Motor Skills Disorder;</li> <li>4) Substance-Related Disorders;</li> <li>5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or</li> <li>6) Narcolepsy and Sleep Disorders related to a General Medical Condition.</li> </ol>	
<b>[Monthly] Benefit</b>	<p><b>LTD/STD</b> 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.]</p>	1, 2 3, 4
<b>Monthly Income Loss</b>	<p><b>LTD/STD</b> means Your Pre-disability Earnings minus Your Current Monthly Earnings.</p>	
<b>[Other Income Benefits]</b>	<p><b>LTD</b> 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:</p> <ol style="list-style-type: none"> <li>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;]</li> <li>2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;</li> <li>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;</li> <li>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</li> </ol>	1 2, 3 4 5 6

## Definitions

- 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.] 7, 8
- 5) [individual insurance policy where the premium is wholly or partially paid by the Employer;] 9
- 6) [mandatory "no-fault" automobile insurance plan;] 10
- 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; 11
- 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;] 12
  - 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 13
  - 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.] 14
- [If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of: 15
- 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. 16

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

### LTD/STD

**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.] 1

### LTD/STD

**Physician** means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Related to You by blood or marriage.

### LTD/STD

**[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

- 1) the [monthly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for: 2
  - a) the [X tax] year(s) just prior to the date of Disability; or 3
  - 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: 4
  - 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. 5, 6

### LTD/STD

**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, 2, 3 4

- 1) [not] including contributions you make through a salary reduction agreement with the Employer to: 5
  - 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. 6, 7

### LTD/STD

**Pre-disability Earnings** means, [for specific class description if applicable], Your regular [monthly] rate of pay, [not including Bonuses, Commissions and Tips and Tokens], 1, 2 3

- 1) [not] including contributions you make through a salary reduction agreement with the Employer to: 4
  - 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.] 5, 6

### LTD/STD

## Definitions

<b>Pre-disability Earnings</b>	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.]	1,2 3
	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. ]	4,5 6
	[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.]	7,8
<b>[Prior Policy]</b>	<b>LTD/STD</b> means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date.	1, 2
<b>Regular Care of a Physician</b>	<b>LTD/STD</b> 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.	
<b>Rehabilitation</b>	<b>LTD/STD</b> 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 similar services.]	1
<b>Rehabilitative Employment</b>	<b>LTD</b> means employment or service which: 1) prepares a Disabled person to resume gainful work; and 2) is approved, in writing, by Us.	
<b>Related</b>	<b>STD</b> 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.] <b>LTD/STD</b>	1

## Definitions

**[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; 1
- 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.]

### **LTD/STD**

**Sickness** means a Disability [or loss] which is: 1

- 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]; 2
  - c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or
  - d) [pregnancy;] 3

caused or contributed to by any medical [or surgical] treatment for a condition shown in item 1) above. 4

### **STD**

## Definitions

<b>Special Condition</b>	<p>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. [Special Condition does not include:</p> <ul style="list-style-type: none"> <li>Arthritis;</li> <li>Herniated intervertebral discs;</li> <li>Scoliosis;</li> <li>Spinal fractures;</li> <li>Osteopathies;</li> <li>Spinal tumors, malignancy, or vascular malformations;</li> <li>Radiculopathies, grade II or higher;</li> <li>Spondylolisthesis, documented by electromyogram;</li> <li>Myelopathies and myelitis;</li> <li>Demyelinating disease;</li> <li>Traumatic spinal cord neurosis;</li> <li>Myofacial pain syndrome;</li> <li>Shoulder sprains and strains;</li> <li>Chronic fatigue syndrome;</li> <li>Fibromyalgia;</li> <li>Carpal tunnel syndrome;</li> </ul> <p>Environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity.]]</p>	1
<b>Spouse</b>	<p>means Your spouse who:</p> <ul style="list-style-type: none"> <li>1) [is under age 60; and</li> <li>2) a citizen or legal resident of the United States [its territories and protectorates]; and</li> <li>3) is not legally separated or divorced from You.]</li> </ul> <p>[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.]</p>	1 2 3
<b>Substance Abuse</b>	<p><b>LTD/STD (non-Employer Market)</b></p> <p>means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:</p> <ul style="list-style-type: none"> <li>1) impairments in social and/or occupational functioning;</li> <li>2) debilitating physical condition;</li> <li>3) inability to abstain from or reduce consumption of the substance; or</li> <li>4) the need for daily substance use to maintain adequate functioning.</li> </ul> <p>[Substance includes alcohol and drugs but excludes tobacco and caffeine.]</p>	1
<b>The Policy</b>	<p><b>LTD/STD</b></p> <p>means the policy which We issued to [The Policyholder under the policy number] shown on the face page.</p>	1
<b>Tips [and Tokens]</b>	<p><b>LTD/STD</b></p> <p>means the [monthly average of monetary] tips and tokens You received from [the Employer] [over:</p> <ul style="list-style-type: none"> <li>1) the [X month] period ending [immediately prior to the date] You became Disabled; or</li> <li>2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]</li> </ul>	1, 2, 3 4, 5 6
<b>Total Disability or Totally Disabled</b>	<p><b>LTD/STD</b></p> <p>means that You are prevented by:</p> <ul style="list-style-type: none"> <li>1) Injury;</li> <li>2) Sickness;</li> <li>3) Mental Illness;</li> <li>4) Substance Abuse; or</li> <li>5) [pregnancy;]</li> </ul> <p>from performing the Essential Duties of Your Occupation,[and as a result, You are earning 20% or less of Your Pre-Disability Earnings.]</p> <p><b>STD</b></p>	1 2

## Definitions

<b>[Total Disability or Totally Disabled]</b>	<p>means disability which:</p> <ol style="list-style-type: none"> <li>1) [during the Elimination Period and the first [24 months] during which Total Disability Benefits are payable, wholly and continuously prevents You from performing the Essential Duties of Your Occupation; and]</li> <li>2) [after that, wholly and continuously prevents You from engaging in Any Occupation.]</li> </ol> <p>[If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain that license does not alone mean that You are disabled from Your Occupation.]</p>	<p>1,2</p> <p>3</p> <p>4</p>
<b>Trust</b>	<p><b>LTD (non-Employer Market)</b> means [the trust fund established by XXX.]</p>	<p>1</p>
<b>We, Our, or Us</b>	<p><b>LTD/STD</b> means [the insurance company named on the face page of The Policy.]</p> <p><b>LTD/STD</b></p>	<p>1</p>
<b>Your Occupation</b>	<p>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.</p> <p>[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.]</p> <p>[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.]</p>	<p>1</p> <p>2</p>
<b>You or Your</b>	<p><b>LTD/STD</b> means the person to whom this certificate is issued.]</p> <p><b>LTD/STD</b></p>	

## Eligibility and Enrollment

<b>Eligible Persons:</b> <i>Who is Eligible for Coverage?</i>	All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.	
	<b>LTD/STD</b>	
<b>Eligibility for Coverage:</b> <i>When will I become Eligible?</i>	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.	1
	See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]	
<b>Enrollment:</b> <i>How do I enroll for coverage?</i>	[For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer.	1
	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.	2
	[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]	3
	[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:]	4, 5
	1) You must give Us Evidence of Insurability satisfactory to Us; and	
	2) [You may only enroll:	6
	a) during an [Annual Enrollment Period] designated by the Policyholder; or	7
	b) within [31 days] of the date You have a Change in Family Status.]	8
	[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]	9
	<b>LTD/STD</b>	
<b>Evidence of Insurability:</b> <i>What is Evidence of Insurability?</i>	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.]	1
	All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.	2
	<b>LTD/STD</b>	
<b>Change in Family Status:</b> <i>What constitutes a Change in Family Status?</i>	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.]	1
	<b>LTD/STD</b>	

**Period of Coverage**

<b>Effective Date:</b> <i>When does my coverage start?</i>	[If You are not required to contribute toward The Policy's cost,] Your coverage will start:	1
	1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or	2
	2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.]	3
	[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:	4
	1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then;	5, 6
	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;	7, 8 9
	3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or]	10, 11
	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.]	12, 13

**LTD/STD**

<b>Effective Date:</b> <i>When does my coverage start?</i>	You [or Your Spouse] will become covered under the Policy on the Certificate Effective Date shown on Your Schedule subject to:	
	1) payment of the required premium; [and	
	2) the Deferred Effective Date provision. ]	1

**LTD (non-Employer Market)**

<b>Effective Date:</b> <i>When does my coverage start?</i>	When You [or Your Spouse] [give Us a satisfactory application] pay the required premium for coverage, then You [or Your Spouse] will become covered under the Policy on the later of:	1
	1) the [Policy] Effective Date;	
	2) the [first day of the month on or next following the] date We receive the request; or	2
	3) if evidence of insurability is required, the [first day of the month on or next following the] date:	3
	a) we determine that You [or Your Spouse] are insurable; or	4
	b) [with respect to the Guaranteed Issue Plan, the date We determine that You [or Your Spouse] are insurable only under such plan;]	5,6
	[subject to the Deferred Effective Date provision.] [However, Your Spouse's, coverage will not become effective prior to the date Your coverage becomes effective. ]	

**LTD (non-Employer Market)**

<b>Deferred Effective Date:</b> <i>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?</i>	If on the date You [or Your Spouse] are to become:	
	1) covered under The Policy; or	
	2) covered for increased benefits under The Policy;	
	and You [or Your Spouse] are not Actively at Work on that date, coverage will not begin until the [first day of the month on or next following the] date You [or he or she] are Actively at Work for [3 months.]	1 2,3

**LTD (non-Employer Market)**

<b>Deferred Effective Date:</b> <i>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?</i>	If You are absent from work due to:	
	1) accidental bodily injury;	
	2) Sickness;	
	3) Mental Illness;	
	4) Substance Abuse; or	
	5) [pregnancy;]	1
	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.	2 3

**LTD/STD**

## Period of Coverage

<b>[Changes in Coverage: Can I change my benefit options?</b>	<p>If You give Us a written request for a change in coverage for which You [or Your Spouse] are eligible [including a request to increase coverage because Your earnings increased] and pay the required premium, the change will become effective on the first day of the month on or next following [the later of:]</p> <ol style="list-style-type: none"> <li>1) the date We receive the request; [or</li> <li>2) if an application is required, the date We determine that You [or Your Spouse] are insurable.]</li> </ol> <p>[If the request increases coverage, the amount of the increase will be subject to the Deferred Effective Date provision.]</p> <p>[If Your Pre-disability Earnings decrease by \$2,000 or more, Your Monthly Benefit will reduce by \$500 effective on the first Premium Due Date following the decrease. You must notify Us of such decrease within [90 days] of its occurrence. Any overpayment of premium resulting from a decrease in the Monthly Benefit will be refunded on a pro-rata basis, but not beyond two years from the date of the decrease.]</p>	<p>1 2 3 4 5</p>
<b>[Changes in Coverage: Can I change my benefit option?</b>	<p><b>LTD (non-Employer Market)</b></p> <p>[You may change Your benefit option only:</p> <ol style="list-style-type: none"> <li>1) during an Annual Enrollment Period; or</li> <li>2) within [31 days] of a Change in Family Status.</li> </ol> <p>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.]]</p>	<p>1 2 3 4</p>
<i>[When will a requested change in benefit option take effect?</i>	<p>[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:</p> <ol style="list-style-type: none"> <li>1) [the first day of the month following the Annual Enrollment Period;] or</li> <li>2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]</li> </ol> <p>[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:</p> <ol style="list-style-type: none"> <li>1) the date You enroll for the change; or</li> <li>2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]</li> </ol> <p>[Any such increase in coverage is subject to the following provisions:</p> <ol style="list-style-type: none"> <li>1) Deferred Effective Date; and</li> <li>2) Pre-existing Conditions Limitations.]] </li></ol>	<p>5 6 7 8, 9 10 11</p>
<i>Do coverage amounts change if there is a change in [my class or] my rate of pay?</i>	<p>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:</p> <ol style="list-style-type: none"> <li>1) are an Active Employee; and</li> <li>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.</li> </ol> <p>No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.</p>	<p>12 13</p>
<i>What happens if the Employer changes the Policy?</i>	<p>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:</p> <ol style="list-style-type: none"> <li>1) the Deferred Effective Date provision; and</li> <li>2) Pre-existing Conditions Limitations.]</li> </ol> <p><b>LTD/STD</b></p>	<p>14</p>

**Period of Coverage**

<b>Continuity From A Prior Policy:</b> <i>Is there continuity of coverage from a Prior Policy?</i>	[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.]	1
 <i>Is my coverage under The Policy subject to the Pre-existing Condition Limitation?</i>	 [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.	 2
	 [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.]	 3, 4 5 6
	 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.]	
 <i>Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?</i>	 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.	 7 8, 9,10

**LTD/STD**

**Period of Coverage**

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

We will automatically cover You [and Your Spouse] under The Policy, subject to:

- 1) payment of the required premium; and
- 2) all the provisions and conditions of The Policy.

Your [and Your Spouse’s] coverage will become effective on [Policy Effective Date]. 1

The Monthly Benefit, Maximum Payment Period and Elimination Period for You [and Your Spouse] in The Policy will most closely approximate those afforded under the Prior Policy on [Policy Effective Date]. 2

A period of Total Disability [or Disabled and Working], including any applicable Elimination Period under the Prior Policy, which began prior to [Date] will be eligible for coverage only under the Prior Policy. Benefits under The Policy will not be payable for a period of Total Disability [or Disabled and Working] which began before [Date]. A period of Total Disability [or Disabled and Working], including any applicable Elimination Period under The Policy, which begins on or after [Date] will be eligible for coverage under The Policy. 3, 4, 5, 6, 7, 8

Successive periods of Total Disability [or Disabled and Working] which are:

- 1) due to the same or related causes; and 10
- 2) not separated by a period of [6 months] or longer; 11

will be considered one period of Totally Disability [or Disabled and Working] and will be payable under the Prior Policy. 12

[If any disability was excluded or limited by a pre-existing condition provision of the Prior Policy, or by a health impairment waiver or rider, of the Prior Policy, the exclusion or limitation for that disability will continue to apply under The Policy to the extent it was excluded or limited under the Prior Policy.]

We will not cover You [and Your Spouse] for any loss or Disability under The Policy resulting from Your [or his or her] Disability which the Prior Policy excluded by name or specific description.

Any Evidence of Insurability required will not apply to You [and Your Spouse] if You [or he or she] are covered under the Prior Policy on the day prior to Effective Date of The Policy. 13

[The Policy means Policy Number [XXXX] issued by Us. 14

**Prior Policy** means[ ] issued by . ]

**LTD (non-Employer Market)**

**Termination:**  
*When will my  
coverage stop?*

Your coverage will end on the earliest of the following:

- 1) [the date] The Policy terminates; 1
- 2) [[the date] The Policy no longer insures Your class;] 2,3
- 3) [the date] premium payment is due but not paid by the Employer; 4
- 4) [the last day of the period for which You make any required premium contribution;] 5
- 5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;] 6
- 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, 8
- 7) [the date Your Employer ceases to be a Participating Employer]. 9

**LTD/STD**

## Period of Coverage

**[Termination:**

*When will my coverage stop?*

- Your coverage [and Your Spouse's coverage] will end on the earliest of:
- 1) [the date the Policy is cancelled;] 1
  - 2) [the date the Policyholder withdraws its sponsorship of, or cancels, the Policy; or] 2
  - 3) [the Premium Due Date on or next following] the date: 3
    - a) You cease to be an active member of the [Policyholder]; 4
    - b) [You [or Your Spouse] attain the Policy Age Limit shown in the Schedule of Insurance;] or 5
  - 4) the date You [or Your Spouse] cease to be Actively at Work, [except due to disability covered by the Policy or temporary lay-off, leave of absence, Family or Medical Leave or Strike or Labor Dispute, as described herein;] 7
  - 5) [the date the Participating Organization ceases to participate;] 8
  - 6) the Premium Due Date any required premium contribution is not made, subject to the Grace Period; or 9
  - 7) [with respect to Your Spouse's coverage, the Premium Due Date he or she is legally separated or divorced from You.

However, if Your Spouse's coverage would terminate because of Your death, coverage will continue until the Premium Due Date on or next following Your death unless continued in accordance with the Surviving Spouse Continuation provision.]

**LTD (non-Employer Market)**

**[Individual**

**Grace Period:**

*What happens if I pay my premiums late?*

- You will be allowed a Grace Period of 31 days from the Premium Due Date for payment of each premium due after the initial premium. Your insurance will be continued during the Grace Period. 1
- The Grace Period will not continue coverage beyond a date shown in the Termination provision.]

**LTD (non-Employer Market)**

**Reinstatement:**

*Can my coverage be reinstated after it ends?*

- If: 1
- 1) Your coverage ends [because You are no longer employed by the Employer or no longer in an eligible class; and] 2,3
  - 2) [You are rehired or return to an eligible class] within [12 months] of the date Your coverage ended; 4
- then coverage for You [and Your previously covered Dependents] may be reinstated, provided You request such reinstatement within [31 days] of the date [You return to work or to an eligible class.] 5,6
- The reinstated coverage will: 7
- 1) [be the same coverage amounts in force on the date coverage ended;
  - 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
  - 3) be subject to all the terms and provisions of The Policy.] 8

[We will not reinstate any amount of coverage which You [or Your Dependent:]

- 1) converted in accordance with the Conversion Right; or
- 2) continued under the Portability Provision;

unless You cancel such coverage.]

**LTD (Optional)**

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

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.] 3, 4

5

## Period of Coverage

[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.] 6  
7

[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.] 8  
9

[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.] 10  
11

[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.] 12, 13  
14

[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.] 15  
16  
17

### LTD/STD

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

### LTD

**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  
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. 2  
After [short term] Disability benefit payments have ceased, Your insurance will be reinstated, provided: 3  
1) You return to work for one full day as a [Full-time] Active Employee in an eligible class; 4  
2) The Policy remains in force; and  
3) the premiums for You were paid during Your Disability, and continue to be paid.]

### STD

**Continuation Provisions:** *Can my insurance be continued?* You may continue Your [and Your Spouse's] coverage under The Policy if You cease to be Actively at Work due [to a temporary lay-off, leave of absence or a leave of absence in accordance with the Family and Medical Leave Act of 1993.] Coverage will continue for [4 weeks], provided: 1  
2  
1) the leave authorization is in writing; and  
2) the required premium is paid.

The Monthly Benefit, Maximum Payment Period and Elimination Period will be the same as were in effect on the day before You were [laid off or the leave began.] 3

Continuation of coverage will not continue beyond the date:  
1) [Your coverage would normally end under the Termination provision; 4  
2) the lay-off becomes permanent; or]  
3) the leave of absence terminates, if prior to the agreed upon date.

### LTD (non-Employer Market)

### Period of Coverage

*[Surviving Spouse Continuation:* If You die while Your Spouse is covered under the Policy, Your Spouse may continue his or her coverage. We must receive Your Spouse's request and the required premium to continue the coverage within [31 days] of the premium due date next following Your death. 1

However, Your Spouse's coverage will not continue beyond:

- 1) a date the coverage would normally end under the Termination provision of The Policy; or
- 2) the premium due date next following the date he or she remarries.]

#### **LTD (non-Employer Market)**

**Waiver of Premium:** *Am I required to pay Premiums while I am Disabled?* We will waive the premium which is due for Your coverage while You are Totally Disabled during the period that: 1,2

- 1) [begins after You have been Totally Disabled for a period of [6 months]; and
- 2) ends when the Total Disability Benefit is no longer payable.

When the Waiver of Premium ceases, You may continue Your coverage under the Policy provided that:

- 1) You resume paying Your premium; and
- 2) Your coverage has not ended in accordance with the Termination provision.]

#### **LTD (non-Employer Market)**

**Waiver of Premium:** *Am I required to pay Premiums while I am Disabled?* No premium will be due for You: [after the Elimination Period; and for as long as benefits are payable.] 1

#### **LTD**

**[Strike or Labor Dispute Waiver of Premium Provision:** *Will my premiums be waived if my Labor Union goes on strike?* In the event You: 1) participate in a lawful strike authorized by Your union; or 2) are locked out as the result of a labor dispute between Your union and Your Employer; We will waive premiums for Your coverage. You must be Actively at Work and covered under The Policy before the strike or lock-out begins. The Waiver of Premium begins on the premium due date next following a [30] consecutive day waiting period, starting after the date the strike or lock-out begins. This provision does not apply to Dependent Spouse coverage. 1

You, or Your labor union, must give Us written notice and proof satisfactory to Us of the strike or lock out.. This provision will not waive premiums for a strike or lock-out which began prior to the [Policy] Effective Date. Satisfactory proof of the status of the strike or lock-out must be given to Us when and as often as we may reasonably require, but in no event less than every [30] days. You must notify us: 2

- 1) as soon as the strike or lock-out is resolved;
- 2) when You return to work;
- 3) are offered the opportunity to return to work for Your employer; or
- 4) when Your employment is terminated.

Premiums will no longer be waived and premium payments must be made on the earliest to occur of: 3

- 1) [one year from the date the waiver began;]
- 2) the premium due date next following the date the strike or lock-out is resolved;
- 3) the premium due date next following the date You return to work or are offered the opportunity to return to work for Your employer; or at the conclusion of the strike or lockout;
- 4) the date You or Your labor union fail to provide satisfactory proof of the status of the strike or lock-out; or
- 5) the date Your employment is terminated.

In no event will premiums be waived beyond the earlier of: 4

- 1) [12 months] from the date the Waiver of Premium began; or
- 2) the date coverage would normally end under the Termination provision of The Policy.

If premiums are not paid when due, Your coverage will terminate.

**Actively at Work** as used in this provision, means You are performing all the Essential Duties of Your Occupation for Your Employer on the date immediately preceding the date the strike or lock-out begins.]

#### **LTD (non-Employer Market)**

**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.

**LTD/STD**

**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 1  
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, 3  
2) [You are under the Policy Age Limit, if any is shown in the Schedule of Insurance;] 4  
3) a Disability is not preventing You from performing duties of Your Occupation; 4  
4) [the insurance for Your class, or] The Policy has not terminated; 5  
5) [You are not eligible for coverage under The Policy under another class; and] 6  
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.

**LTD**

*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. 1

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.

**LTD**

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

If You cease to be insured under The Policy because:  
1) You are no longer a member of the Policyholder; or  
2) the Policyholder terminates its sponsorship of The Policy;  
You will have the right to request conversion coverage without giving medical Evidence of Insurability. Such coverage will be issued under another group policy.

To convert Your coverage You must:

- 1) give Us a request for the conversion coverage; and
- 2) pay the initial premium;

within [31 days] after You cease to be covered under The Policy. 1

Coverage under the conversion Policy will be effective on the day following the date coverage under The Policy terminates, provided You:

- 1) had been continuously covered for at least [12 consecutive months] under The Policy, or under The Policy and the Prior Policy; 2
- 2) [are under the Policy Age Limit; and] 3
- 3) are not Totally Disabled.

The conversion coverage:

**Period of Coverage**

- 1) will have the provisions, limitations and exclusions on the form We are issuing for this purpose at the time of conversion;
- 2) will not provide any benefit other than the Total Disability Benefit;
- 3) will not exceed Your Monthly Benefit under The Policy; and
- 4) will base premiums on the rates in effect for new applicants of [Your class] and age at the time of conversion. 4

**LTD (non-Employer Market)**

**Portability:** *Can I continue my coverage if my employment ends?*

If You cease to be an Active Employee for any reason other than Your retirement or a leave of absence, and if: 1

- 1) You have been covered under The Policy for at least [12 consecutive months] before Your employment ends; 2
- 2) You are not Disabled;
- 3) You are not absent due to a labor strike; and
- 4) You are not covered under any other group insurance plan,

Then You may be able to continue Your coverage for up to [12 months] from the date You ceased to be an Active Employee. 3

You must apply in writing and pay the first premium to Us within [31 days] after the date Your employment ends. 4

The insurance continued is the insurance in effect on the date your employment ends, including the Weekly Benefit, Benefits Commence, Maximum Duration of Benefits and Pre-disability Earnings.

Insurance continued under this provision will cease on the earliest of:

- 1) the date The Policy terminates;
- 2) the last day of the period for which You make any required premium contribution;
- 3) the date You become a full-time member of the armed forces of any country;
- 4) the end of the 12 month period during which Your coverage is continued under this Portability provision;
- 5) the date you become covered under any other group insurance plan;
- 6) the end of a 6 month period during which Your coverage is continued under this Portability provision and you are not employed with any employer.]

**LTD (non-Employer Market)**

## Benefits

<b>Disability Benefit:</b> <i>When do I qualify for Disability Benefits?</i>	<p>We will pay You a Monthly Benefit if You:</p> <ol style="list-style-type: none"> <li>1) become Disabled while insured under The Policy;</li> <li>2) are Disabled throughout the Elimination Period;</li> <li>3) remain Disabled beyond the Elimination Period; and</li> <li>4) submit Proof of Loss to Us.</li> </ol> <p>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.</p> <p><b>LTD</b></p> <p>If You [or Your Spouse] become Totally Disabled as the result of [an Injury or Sickness] while covered under The Policy, We will pay the [Monthly] Benefit due for the period of Total Disability. [The period of Total Disability must require the Regular Care of a Physician.]</p> <p>We will not pay benefits for any part of a period of Total Disability that:</p> <ol style="list-style-type: none"> <li>1) [is applied to the Elimination Period; or</li> <li>2) exceeds the Maximum Payment Period.]</li> </ol> <p>[However, if You are Totally Disabled due to Mental Illness, alcoholism or Substance Abuse, the Maximum Payment Period will be reduced to 2 years during Your lifetime unless You are confined in a hospital or other institution licensed to provide care and treatment for that disability.]</p> <p>[The Elimination Period and Maximum Payment Period apply separately to each period of Total Disability.]</p>	1 2,3 4 5 6
<b>Disability Benefit:</b> <i>When do I qualify for Disability Benefits?</i>	<p><b>LTD (non-Employer Market)</b></p> <p>If You [or Your Spouse] become Totally Disabled as the result of [an Injury or Sickness] while covered under the Policy:</p> <ol style="list-style-type: none"> <li>1) We will pay the [Monthly Benefit for each month of Total Disability;] and</li> <li>2) at the end of the Maximum Payment Period, provided You [or Your Spouse] continue to meet the definition of Total Disability, We will pay a one-time additional Lump Sum Benefit.</li> </ol> <p>[The period of Total Disability must require the Regular Care of a Physician.]</p> <p>We will not pay benefits for any part of a period of Total Disability that:</p> <ol style="list-style-type: none"> <li>1) [is applied to the Elimination Period; or</li> <li>2) with respect to the Monthly Benefit, exceeds the Maximum Payment Period.]</li> </ol> <p>[However, if You are Totally Disabled due to Mental Illness, alcoholism or Substance Abuse, the Maximum Payment Period for the Monthly Benefit will be reduced to 2 years during Your lifetime unless You are confined in a hospital or other institution licensed to provide care and treatment for that disability.]</p> <p>[The Elimination Period, Maximum Payment Period, Monthly Benefit and Lump Sum Amount apply separately to each period of Total Disability.]</p>	1 2 3 4 5 6
<b>Disability Benefit:</b> <i>When do I qualify for Disability Benefits?</i>	<p><b>LTD (non-Employer Market)</b></p> <p>If, while covered under this Benefit, You:</p> <ol style="list-style-type: none"> <li>1) become Totally Disabled;</li> <li>2) remain Totally Disabled; and</li> <li>3) submit Proof of Loss to Us;</li> </ol> <p>We will pay the Weekly Benefit.</p> <p>[The amount of any Weekly Benefit payable will be reduced by:</p> <ol style="list-style-type: none"> <li>1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and</li> <li>2) any income received from [the Employer] for the period You are Totally Disabled.]</li> </ol>	1 2
<b>[Minimum Weekly Benefit:</b> <i>Is there a</i>	<p><b>STD</b></p> <p>Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.]</p>	3

## Benefits

*Minimum Weekly Benefit?*

<b>Partial Week Payment:</b> <i>How is a benefit calculated for a period of less than a week?</i>	<b>STD</b> 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.	4
<b>Mental Illness And Substance Abuse Benefits:</b> <i>Are benefits limited for Mental Illness [or Substance Abuse?]</i>	<p><b>STD</b> If You are Disabled because of:</p> <ol style="list-style-type: none"> <li>1) Mental Illness that results from any cause;</li> <li>2) any condition that may result from Mental Illness;</li> <li>3) alcoholism [which is under treatment]; or</li> <li>4) [the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance];</li> </ol> <p>then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.</p> <p>[Benefits will be payable for a total of [24 months, ] unless at the end of the [24 month] period:</p> <ol style="list-style-type: none"> <li>1) You are confined in a hospital or other place licensed to provide medical care for the disabling condition, in which case:               <ol style="list-style-type: none"> <li>a) benefits will continue during the confinement; and</li> <li>b) if You are still Disabled when discharged, benefits will continue for a recovery period of up to [90 days;] and</li> <li>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;]</li> </ol> </li> <li>or</li> <li>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.]</li> </ol>	<p>1</p> <p>2</p> <p>3, 4, 5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p>
<b>Substance Abuse Limitation:</b> <i>Are benefits limited for alcoholism or Substance Abuse?</i>	<p><b>LTD</b> If You are Disabled because of:</p> <ol style="list-style-type: none"> <li>1) alcoholism [under treatment]; or</li> <li>2) the non-medical use of narcotics, [sedatives, stimulants, hallucinogens, or any other such substance];</li> </ol> <p>then, subject to all other Policy provisions, benefits will be payable for [as long as] You are:</p> <ol style="list-style-type: none"> <li>1) confined in a hospital or other place licensed to provide medical care for the disabling condition; or</li> <li>2) actively participating in a rehabilitative program approved by Us.</li> </ol>	<p>1</p> <p>2</p> <p>3</p>
<b>Special Conditions Limitation:</b> <i>Are benefits limited for Special Conditions?</i>	<p><b>LTD</b> If You are Disabled due to a Special Condition, then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.</p> <p>Benefits will be payable:</p> <ol style="list-style-type: none"> <li>a. for as long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or,</li> <li>b. if not confined, or after you are discharged and still disabled, for a total of [24 months] for all such disabilities during your lifetime.</li> </ol> <p>After a period of Disability due to a Special Condition, if you again become Actively at Work and remain continuously insured under The Policy for a period of at least [24 months], then this Special Conditions Limitation may be reinstated.</p>	<p>1</p> <p>2</p> <p>3</p>

### LTD/STD (Optional)

## Benefits

<b>Recurrent Disability:</b> <i>What happens if I recover but become Disabled again?</i>	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.]	1
	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 [3] months of the return to work,	2
	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 [3] 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.	3
	<b>Period of Disability</b> _ means a continuous length of time during which You are Disabled under The Policy.	
	<b>Recover or Recovery</b> means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.	
	<b>LTD</b>	
<b>Recurrent Disability:</b> <i>What happens if I recover but become Disabled again?</i>	[If You cease to be Totally Disabled and return to work for a total of [14 days] or less during the Elimination Period, the Elimination Period will not be interrupted. Except for the [14 days] or less that You work, You must be Totally Disabled by the same condition for the total Elimination Period.]	1
	Periods of Disability: 1) due to the same or related medical causes; and 2) separated by less than [6 months] during which You are Actively at Work;	2
	will be considered one Period of Disability.	3
	Periods of Disability separated by at least [6 months] during which You are Actively at Work will be considered separate Periods of Disability.	4
	[Benefits during any Period of Disability as the result of: 1) more than one Sickness; or 2) more than one Injury; or 3) both Sickness and Injury;	5
	will be considered the same as if the disability resulted from only one cause.]	
	<b>Period of Disability</b> means a continuous length of time during which You are disabled under The Policy.	
	<b>LTD (non-Employer Market)</b>	
<b>Recurrent Disability:</b> <i>What happens to my benefits if I return to work as an Active Employee and then become Disabled again?</i>	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;	1, 2
	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.	3
	<b>Period of Disability</b> means a continuous length of time during which You are Disabled under The Policy.	
	<b>STD</b>	
<b>Multiple Causes:</b> PAL-DI-10-C-AR	If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly	

## Benefits

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

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.

1

**STD**

## Benefits

<b>Calculation of Monthly Benefit:</b>	If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefit [during the Initial Benefit Period] as follows:	1
<i>How are my Disability benefits calculated [during the Initial Benefit Period]?</i>	<ol style="list-style-type: none"> <li>1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage ;</li> <li>2) compare the result with the Maximum Benefit ; and</li> <li>3) from the lesser amount, deduct Other Income Benefits.</li> </ol> <p>The result is Your Monthly Benefit.</p>	2, 3
<i>How are Disability benefits calculated?</i>	<p>If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefits as follows:</p> <ol style="list-style-type: none"> <li>1) multiply Your Monthly Income Loss by the Benefit Percentage;</li> <li>2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage; and from this product subtract all Other Income Benefits; and</li> <li>3) identify the Maximum Benefit.</li> </ol> <p>The calculation giving the least amount is Your Monthly Benefit.</p> <p><b>LTD</b></p>	
<b>Calculation of Monthly Benefit: Return to Work Incentive: How are my Disability benefits calculated?</b>	<p>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:</p> <ol style="list-style-type: none"> <li>1) multiply Your Pre-Disability Earnings by the [Initial] Benefit [Period] Percentage;</li> <li>2) compare the result with the Maximum Benefit; and</li> <li>3) from the lesser amount, deduct Other Income Benefits.</li> </ol> <p>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 [80%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.</p>	1 2,3
	<p>The [12 consecutive month] period will start on the last to occur of:</p> <ol style="list-style-type: none"> <li>1) the day You first start work; or</li> <li>2) the end of the Elimination Period.</li> </ol>	4 5
	<p>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:</p> <ol style="list-style-type: none"> <li>1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage;</li> <li>2) compare the result with the Maximum Benefit; and</li> <li>3) from the lesser amount, deduct Other Income Benefits.</li> </ol> <p>The result is Your Monthly Benefit.</p> <p><b>LTD</b></p>	6 7, 8

## Benefits

**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

- 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 [80%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess. 2

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;
- 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.

### LTD

**Calculation of Monthly Benefit:** *How are my Disability benefits calculated during the Continuing Benefit Period?*

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

- 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: 2

- 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.

### LTD

**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

- 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 [80%] of your Pre-disability Earnings, we will reduce your Monthly Benefit by the amount of excess. 2

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.

## Benefits

<b>Calculation of Monthly Benefit:</b> <i>What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-disability Earnings?</i>	<p><b>LTD</b></p> <p>If the sum of Your [Monthly/Weekly Benefit, Current Monthly/Weekly Earnings and Other Income Benefits] exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.</p> <p>[However, Your Monthly/Weekly Benefit will not be less than the Minimum Monthly/Weekly Benefit.]</p> <p>[If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.]</p>	1 2 3
<b>Calculation of Monthly Benefit: Return to Work Incentive</b> <i>How are my Disability benefits calculated?</i>	<p><b>LTD</b></p> <p>If You remain Disabled after the Elimination Period[, and are earning more than [20%] of Your [Indexed] Pre-disability Earnings,] We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as [follows:</p> <ol style="list-style-type: none"> <li>1) multiply Your Pre-Disability Earnings by the [Initial] Benefit [Period] Percentage;</li> <li>2) compare the result with the Maximum Benefit; and</li> <li>3) from the lesser amount, deduct Other Income Benefits.</li> </ol> <p>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, Other Income Benefits and Your Current Monthly Earnings exceeds [80%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.</p> <p>The [12 consecutive month] period will start [on the last to occur of:</p> <ol style="list-style-type: none"> <li>1) the day You first start work [and are earning more than [20%] of Your [Indexed] Pre-disability Earnings]; or</li> <li>2) the end of the Elimination Period.]</li> </ol> <p>If You remain Disabled, are not receiving benefits under the Return to Work Incentive described above, [and are earning more than [20%] of Your [Indexed] Pre-disability Earnings,] We will calculate Your Monthly Benefit as [the greater of:</p> <ol style="list-style-type: none"> <li>1) the Proportionate Loss Formula; or</li> <li>2) the 50% Offset Formula.]</li> </ol> <p><b>[Proportionate Loss Formula: (A divided by B) x C = D, where:</b></p> <p><b>A</b> = Your [Indexed] Pre-disability Earnings minus Your Current Monthly Earnings;</p> <p><b>B</b> = Your [Indexed] Pre-disability Earnings;</p> <p><b>C</b> = the Monthly Benefit which would be payable if You were Disabled [and not earnings more than [20%] of Your [Indexed] Pre-disability Earnings]; and</p> <p><b>D</b> = the Monthly Benefit payable.]</p> <p><b>[50% Offset Formula: (W – X) – Y = Z, where:</b></p> <p><b>W</b> = the Maximum Benefit;</p> <p><b>X</b> = 50% of Your Current Monthly Earnings;</p> <p><b>Y</b> = all Other Income Benefits; and</p> <p><b>Z</b> = the Monthly Benefit payable. ]</p>	1 2 3 4 5 6 7 8 9 10 11 12
<b>Minimum Monthly Benefit:</b> <i>Is there a Minimum Monthly Benefit?</i>	<p><b>LTD</b></p> <p>Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.</p> <p><b>LTD</b></p>	

## Benefits

**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.

### LTD

**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.

### LTD

**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;] ] 1, 2
- 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;] 3
- 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;] 4
- 7) [the last day benefits are payable according to the Maximum Duration of Benefits Table; or] 5
- 8) [the date Your Current Monthly Earnings: 6
  - 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 7, 8
  - 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;]] 10, 11
- 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: 12
  - 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 13
  - b) You immediately transfer the payment to another plan qualified by the United States

**Benefits**

Internal Revenue Service for the funding of a future retirement.]

**LTD**

**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; 1, 2
  - 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;] ] 1, 2
  - 4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;] 3
  - 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; ] 4
  - 7) [the last day benefits are payable according to the Maximum Duration of Benefits;] 5
  - 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 6,7  
8
  - 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: 9, 10
    - 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;] 11
    - 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 12
  - 11) [the date You receive retirement benefits from any employer's Retirement plan, unless: 13
    - 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.]

**STD**

**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: 1

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

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.] 2

**STD (optional)**

**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.] 1  
2

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.] 3

**STD (optional)**

**Benefits**

<b>Disabled and Working Benefits:</b> <i>How are benefits paid when I am Disabled and Working?</i>	<p>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]:</p> <ol style="list-style-type: none"> <li>1) multiply Your Pre-Disability Earnings by the Benefit Percentage; and</li> <li>2) compare the result with the Maximum Benefit; and</li> <li>3) from the lesser amount deduct Other Income Benefits.</li> </ol> <p>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.]</p> <p>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.</p> <p>[Days which You are Disabled and Working may be used to satisfy the Benefits Commence/Elimination Period.]</p> <p><b>STD (optional)</b></p> <p>If You are Disabled and Working, we will pay a [Weekly/Monthly] Benefit for each month You are Disabled.</p> <p>The Disability must begin:</p> <ol style="list-style-type: none"> <li>1) before You attain [age 60]; and</li> <li>2) while You are covered under this benefit.</li> </ol> <p>[Payment will begin on the first day following the last day for which the Disability Benefit has been payable.</p> <p>Payment will begin on the first day following the day You have been Disabled and Working for as long as You would have been required to be Totally Disabled in order to have satisfied the Disability Elimination Period, whether or not You are Totally Disabled.]</p> <p>[We will not pay for any part of a period that You are Disabled and Working that exceeds the Maximum Payment Period for this Benefit for any one Injury or any one Sickness.]</p> <p>[To determine the Disabled and Working Monthly Benefit, use the following calculation:</p> <p align="center"><b>(A divided by B) x C = D</b></p> <p><b>A</b> = Your [Indexed] Pre-disability Earnings less Your Current Monthly Earnings.</p> <p><b>B</b> = Your [Indexed] Pre-disability Earnings.</p> <p><b>C</b> = The Monthly Benefit payable if You were otherwise Totally Disabled. (Disregard all other income from any employer or for any work when determining this figure).</p> <p><b>D</b> = The Disabled and Working Monthly Benefit payable.]</p> <p><b>[Indexed Pre-disability Earnings]</b> means Pre-disability Earnings, as defined, adjusted annually by [X%]. The first adjustment will occur on the July 1<sup>st</sup> after You have been Disabled for a full calendar year. After the first adjustment, Your Pre-Disability Earnings will be increased by an additional [X%] on each following July 1<sup>st</sup> up to a maximum of [5] adjustments.]</p> <p>If a Disabled and Working Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day You are Disabled and Working. This minimum Monthly Benefit will never be less than [\$50.00.]</p> <p>The Maximum Payment Period [is shown in the Schedule of Insurance and is applied separately to each Disability.]</p> <p>Disabled and Working Benefit payments will cease on the first to occur of:</p> <ol style="list-style-type: none"> <li>1) [the date Your monthly earnings while You are Disabled and Working exceed [80%] of Your Indexed Pre-Disability Earnings; or</li> </ol>	<p>1</p> <p>2</p> <p>3</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7,8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13, 14</p>
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**Benefits**

- 2) the date You are eligible for benefits under the Disability Benefit due to the same or related causes; or
- 3) the date You return to work in an occupation other than Your own.]

**Disabled and Working** means a Disability that:

- 1) [is caused by the same Injury or Sickness that caused the Total Disability that immediately preceded the period You are Disabled and Working;] 15
- 2) continues while You are performing at least one of the material duties of Your own occupation on either a full-time or part-time basis;
- 3) [causes a loss of earnings of at least 20% (and less than 80%); and] 16
- 4) requires the Regular Care of a Physician.

A disability that causes a loss of earnings of [80%] or more is considered to be a Total Disability and will be payable under the Total Disability Benefit. 17

**LTD (non-Employer Market)**

**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. 1

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. 2

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. 3

**STD (optional)**

## Benefits

**[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. 1

**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: 2

- 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: 3

- 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.]]

### **LTD (Optional)**

## 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 1
  - 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) [\$200] during the first [6] months of Rehabilitation ; and 2, 3
  - b) [\$X] thereafter; 4

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; 5
- 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 [12] months have been deducted during Your Disability; and 6
- 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. 7, 8

### **LTD (optional)**

### **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
- 1) You have been Disabled for [12 consecutive months]; and 2
  - 2) [You are receiving benefits;] [and 3
  - 3) Your Current Monthly Earnings are less than or equal to 20% of Your Pre-disability Earnings;] 4
- when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1<sup>st</sup>.] 5

*What is the Cost-of-Living Adjustment formula?*

- We apply the Cost-of-Living Adjustment formula by:
- 1) determining the lesser of:
    - a) [% ]; or 6
    - b) [1/2] the percentage change in the Consumer Price Index; 7
  - 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 8
  - 2) You have received [5] adjustments;] or 9
  - 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 ]. 10

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.

### **LTD/STD (optional)**

## Benefits

<b>Survivor Income Benefit:</b> <i>Will my survivors receive a benefit if I die while receiving Disability Benefits?</i>	If You were receiving a Monthly/Weekly [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: <ol style="list-style-type: none"><li>1) of Your death; and</li><li>2) that the person claiming the benefit is entitled to it.</li></ol> [We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.]	1, 2 3, 4
	[[We will pay the Survivor Income Benefit: <ol style="list-style-type: none"><li>1) to the beneficiary You designated; or</li><li>2) if no beneficiary has been designated:<ol style="list-style-type: none"><li>a) to Your Surviving Spouse; or</li><li>b) if no Surviving Spouse, in equal shares to Your Surviving Children;</li><li>c) [if no Surviving Spouse or Surviving Children, to Your estate.]</li></ol></li></ol>	5 6 7 8
	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/Weekly Benefit/is calculated as [3] times the lesser of]: <ol style="list-style-type: none"><li>1) Your Monthly/Weekly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or</li><li>2) The Maximum Monthly Benefit.]</li></ol>	9, 10
	[To designate or change Your designation of beneficiary, You must file a written notice with [the Policyholder] 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.]	11 12
	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.]	13
	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: <ol style="list-style-type: none"><li>1) [lived with You in a regular parent-child relationship; and</li><li>2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.]</li></ol>	14 15 16 17 18
	[In the event that You are diagnosed with a Terminal Illness while You are: <ol style="list-style-type: none"><li>1) eligible for a Monthly/Weekly Benefit under the Policy; and</li><li>2) at least [6] Monthly/Weekly Benefit Payments remain payable to You;</li></ol> We will pay the Survivor Income Benefit to You on an accelerated basis in one lump sum if: <ol style="list-style-type: none"><li>1) [You submit a request that the Survivor Income Benefit be paid on an accelerated basis; and</li><li>2) We receive proof that You have been diagnosed with a Terminal Illness.</li></ol>	19 20 21
	If the Survivor Income Benefit is paid on an accelerated basis, no additional benefit will be payable under this benefit upon Your death.	22
	1) [Terminal Illness or Terminally Ill means a life expectancy of [6] months or less.]	23

### LTD (optional)

## Benefits

**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; 1, 2
- 2) now be working [Full-time] for the Employer [or another employer;] 3
- 3) be performing all the Essential Duties of Your Occupation [or another occupation;] 4
- 4) as a result of having been so Disabled, be currently earning less than [60%] 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. 5, 6

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; 7
  - 2) the date You are earning at least [60%] of Your Pre-disability Earnings; or 8
- 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?*

**LTD (optional)**

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.

**LTD (optional)**

## 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.

**LTD (optional)**



**Benefits**

**Payable**

**For Complete Fracture of Bones**

Skull (except bones of face or nose), both tables..... 13 Weeks  
 Thigh (shaft) ..... 12 Weeks  
 Arm, between elbow and shoulder (shaft) ..... 12 Weeks  
 Pelvis (except coccyx) ..... 10 Weeks  
 Vertebra or Vertebrae (except coccyx and vertebral processes)..... 10 Weeks  
 Shoulder Blade ..... 8 Weeks  
 Leg (shaft) ..... 8 Weeks  
 Kneecap ..... 8 Weeks  
 Collar Bone..... 6 Weeks  
 Forearm, between wrist and elbow (shaft)..... 6 Weeks  
 Foot (except toes) ..... 5 Weeks  
 Hand (except fingers) ..... 5 Weeks  
 Lower Jaw (except alveolar process)..... 3 Weeks  
 One or more ribs, fingers or toes ..... 2 Weeks  
 Bones of face or nose..... 2 Weeks  
 Coccyx or Vertebral Processes ..... 1 Week

**For Complete Dislocation**

Hip Joint ..... 12 Weeks  
 Knee Joint (except patella) ..... 6 Weeks  
 Bone or Bones of Foot (except toes) ..... 6 Weeks  
 Ankle Joint..... 6 Weeks  
 Wrist Joint ..... 5 Weeks  
 Elbow Joint..... 4 Weeks  
 Shoulder Joint..... 3 Weeks  
 Bone or Bones of Hand (except fingers) ..... 2 Weeks  
 Collar Bone..... 2 Weeks  
 One or more fingers or toes ..... 1 Week

**For Loss By Removal**

Of one or more entire toes ..... 8 Weeks  
 Of one or more fingers (at least one entire phalanx)..... 6 Weeks]

**LTD (non-Employer Market)**

If You are Confined in a Hospital:

- 1) while covered under the Policy; and
- 2) due to [Sickness or Injury];

then we will pay [the Daily Benefit] for [each Day of Confinement,] [up to the Maximum Payment Period.]

1  
2,3,4

5

[The Daily Benefit and the Maximum Payment Period are shown in the Schedule of Insurance.] [If Hospital Confinement is due to a Mental Illness or Substance Abuse, the Maximum Payment Period will be 10 days per Period of Confinement, with a maximum lifetime aggregate of 60 days.]

6

7

[Successive periods of Hospital Confinement:

- 1) due to the same or related causes; and
- 2) separated by less than [90 days;]

8

are considered one period of Hospital Confinement. A new period of Hospital Confinement begins when You are readmitted to a Hospital;

9

- 1) for a new Sickness or Injury unrelated to the cause of a prior Confinement; or
- 2) after You have been free of Hospital Confinement for [90 days] or more. ]

10

**Exclusion:** This benefit does not cover Confinement in a Department of Veterans Affairs or any other National Government owned or operated Hospital.

11

**Confined or Confinement** means being an inpatient in a Hospital due to [Sickness or Injury.]

12

[**Day of Confinement** means a day of inpatient Confinement in a Hospital for which a daily room and board charge is made for a full day of Confinement.]

**Hospital Income Benefit:** What benefits are payable if I am Confined in a Hospital?

## **Benefits**

**Hospital** means an institution which:

- 1) operates pursuant to law;
- 2) primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
- 3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
- 4) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.)

Hospital **does not mean** any institution or part thereof which is used primarily as:

- 1) a nursing home, convalescent home, or skilled nursing facility;
- 2) a place for rest, custodial care, or for the aged;
- 3) a clinic;
- 4) a place for the treatment of Mental Illness, alcoholism or Substance Abuse.

However, a place for the treatment of Mental Illness, alcoholism or Substance Abuse will be regarded as a Hospital if:

- 1) it is part of an institution that meets the above requirements; and
- 2) it is listed in the American Hospital Association Guide as a general hospital.

**Period of Confinement** means an interval of time during which You [or Your Spouse] are Confined as an inpatient in a Hospital. A Period of Confinement begins on the date You [or Your Spouse] are admitted to the Hospital.

**LTD (non-Employer Market)**

## Benefits

### 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; 1
- 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: 2
- a) [during or after the Elimination Period, and] 3
- 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: 4

- 1) [\$5000]; or 5
- 2) the Maximum Monthly Benefit.]

[The maximum payment period for this benefit will be [X years].] 6

[We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30<sup>th</sup> of the Activities of Daily Living Benefit for each day of covered loss.] 7

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 8
- 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 9, 10
- 3) You reach the maximum payment period shown in this benefit.]

**Cognitively Impaired** 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.

**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
- 6) feeding Yourself, once the food has been prepared and made available to You.

**LTD (optional)**

**Benefits**

**Accidental  
Dismemberment  
and Loss of  
Sight Benefit:**

*What benefits are payable for dismemberment or loss of sight due to an Injury?*

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. 1

<b>For Loss of</b>	<b>Minimum Number of Monthly Benefit Payments</b>	
[Both Eyes.....]	46	2
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: 3
- 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.

**LTD (optional)**

## Benefits

<b>Medical Premium Supplement Benefit:</b> <i>Does The Policy also cover premium contributions for continuance of Medical coverage?</i>	<p>If You:</p> <ol style="list-style-type: none"> <li>1) become Disabled while You are covered under this Medical Premium Supplement Benefit;</li> <li>2) are receiving a Monthly Benefit under The Policy; and</li> <li>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;</li> <li>4) have not had a lapse in Your [COBRA coverage] [coverage under [Your Employer’s]] Medical Plan during the elimination period; and</li> <li>5) are not eligible for Medicare,</li> </ol> <p>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]:</p> <ol style="list-style-type: none"> <li>1) [\$[X] per month] [;or]</li> <li>2) the actual amount of premium You pay to [Your Employer] to continue coverage [under Your Medical Plan] [pursuant to COBRA].</li> </ol> <p>You will cease to receive a Medical Premium Supplement Benefit when:</p> <ol style="list-style-type: none"> <li>1) You cease to be Disabled; [or</li> <li>2) You have received payments under this benefit for [X months;]]</li> <li>3) [Your coverage under [Your Employer’s] Medical Plan ends due to Your failure to pay premiums for that coverage;]</li> <li>4) [COBRA continuance under [Your Employer’s] Medical Plan ends for any reason;]</li> <li>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;</li> <li>6) You obtain coverage for Yourself [or Your dependents] under another group Medical Plan; [or</li> <li>7) The Policy terminates].]</li> </ol> <p>[<b>COBRA</b> means the Consolidated Omnibus Reconciliation Act of 1985, as amended, including changes made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).]</p> <p>[<b>Medical Plan</b> means a program that:</p> <ol style="list-style-type: none"> <li>1) provides health insurance or medical coverage to Your [and Your dependents]; and</li> <li>2) for which You are eligible as a result of employment with [the Employer].</li> </ol> <p>Medical Plan does not include:</p> <ol style="list-style-type: none"> <li>1) [coverage for Your dependents];</li> <li>2) accident-only or disability income insurance;</li> <li>3) [limited scope,] [dental,] [vision,] benefits];</li> <li>4) long term care/nursing home care/home health care coverage or any combination thereof;</li> <li>5) Medicare supplemental coverage;</li> <li>6) Specified disease coverage;</li> <li>7) Hospital confinement indemnity insurance; or</li> <li>8) Other similar types of insurance coverage designed to provide limited, incidental or supplemental benefits.]</li> </ol> <p>[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.]</p> <p>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.</p>	<p>1 2,3 4,5 6,7,8 9 10,11, 12,13 14</p> <p>15 16 17 18 19 20 21 22</p> <p>23</p> <p>24</p> <p>25 26,27, 28</p> <p>29 30 31 32</p>
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### LTD (Optional)

**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.

1

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

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

2, 3

4

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

5

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

where

*Is a benefit paid if I am Disabled and Working?*

A = Your Pre-Disability Earnings

B = Your current [Monthly] earnings

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

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.

6

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8

*How long will this benefit be paid?*

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

**Cafeteria Plan Election Restriction**

**LTD (optional)**

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?*

**LTD/STD (optional)**

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

1

2

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

**LTD**

## Exclusions and Limitations

<b>Exclusions: What Disabilities are not covered?</b>	[The Policy does not cover, and We will not pay a benefit for any Disability:	1
	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);	2
	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];	3, 4
	6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer;	5
	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.]	
	<b>LTD/STD</b>	
<b>Exclusions: What Disabilities are not covered?</b>	[This Policy does not cover any Disability or loss caused by:	1
	1) intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; or	
	2) pregnancy or childbirth, except Complications of Pregnancy; or	
	3) war or act of war, whether declared or not; or	
	4) any [Sickness or Injury] for which workers' compensation benefits are paid, or may be paid if duly claimed; or	
	5) any Injury sustained while riding on, boarding or alighting from, any aircraft:	
	a) as a pilot, crew member or student pilot;	
	b) operated by any military authority (land, sea or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Military Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or	
	c) being used for tests, experimental purposes, stunt flying, racing or endurance tests; or	
	6) Your commission or attempted commission of a felony; or	
	7) Sickness contracted or Injury sustained while on full-time active duty as a member of the Armed Forces (land, water, air) of any country or international authority.	
	 We will refund the pro rata portion of any premium paid for You while You are in the Armed Forces on full-time active duty for a period of two months or more. [Written] notice must be given to Us within 12 months of the date You enter the Armed Forces.]	2
	<b>LTD (non-Employer Market)</b>	
<b>Pre-existing Condition</b>	<b>Conditions Prior to Effective Date:</b> We will not pay a Benefit for any loss or period of Total Disability which:	
<b>Limitation: Are benefits limited for Pre-existing Conditions?</b>	1) begins during the first [year] of Your insurance; and	1
	2) is a result of a Pre-existing Condition;	
	[unless such Total Disability begins after You have been free of Medical Care for the condition for a one year period ending any time on or after Your effective date.]	2
	 <b>Conditions Prior to Effective Date of Increase in Coverage:</b> We will not pay an increased Benefit for any loss or period of Total Disability which:	
	1) begins during the first [year] following the date You make a change in coverage that increases Your benefits; and	3
	2) is a result of a Pre-Existing Condition;	
	[unless such Total Disability begins after You have been free of Medical Care for the condition for a one year period ending any time on or after Your effective date of increase.]	4
	 <b>Pre-existing Conditions</b> means any Disability, diagnosed or undiagnosed, for which Medical Care is received by You:	
	1) within the [6 month] period prior to the date Your insurance starts; or	5
	2) with respect to the limitation for any increase in coverage, within the [6 month] period prior to the effective date of Your increase in coverage.	6

## Exclusions and Limitations

**Medical Care** is received when:

- 1) a Physician is consulted or medical advice is given; or
- 2) Treatment is recommended or prescribed by, or received from a Physician.

**Treatment** includes, but is not limited to:

- 1) medical examination, test, attendance, or observation;
- 2) medical services, supplies, or equipment, including their prescription or use; or
- 3) prescribed drugs or medicines, including their prescription or use.

All manifestations, symptoms, or findings which result:

- 1) from the same or related Disability; or
- 2) from any aggravations of that Disability;

are considered to be the same Disability for the purpose of determining a Pre-Existing Condition.

### [Health Waiver and Application Modification Form

If Your Pre-existing Condition was excluded or limited by name or specific description on a Health Waiver and Application Modification form attached to Your certificate, then such Pre-existing Condition will not be covered under the Policy at any time, unless You complete an Application Requesting Removal of Waiver, and We agree in writing to remove the limitation on that condition.]

7

### LTD (non-Employer Market)

#### 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)].

1

2

3

4

**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;

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for which You received Medical Care during the [180] day period that ends the day before:

7

- 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.

**LTD/STD**

## General Provisions

<b>Notice of Claim:</b> <i>When should I notify the Company of a claim?</i>	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.]	1, 2, 3 4  5 6
<b>Claim Forms:</b> <i>Are special forms required to file a claim?</i>	<b>LTD/STD</b> 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.]	1, 2 3 4  5
<b>Proof of Loss:</b> <i>What is Proof of Loss?</i>	<b>LTD/STD</b> [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.	1
<b>Additional Proof of Loss:</b> <i>What additional proof of loss is the Company entitled to?</i>	<b>LTD/STD</b> 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.	
<b>Sending Proof of Loss:</b> <i>When must proof of Loss be given?</i>	<b>LTD/STD</b> 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.	1  2 3

**General Provisions**

**Claim Payment:** When We determine that You;  
*When are benefit payments issued?* 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. 1

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.

**LTD/STD**

**Claim Payment:** Periodic benefit payments will be made on a [monthly] basis after We receive the Proof of Loss satisfactory to Us and will continue while the loss and Our liability continue. We will pay any other benefit due immediately after We receive the Proof of Loss satisfactory to Us. [We will pay any benefit for loss of life under the Accidental Death and Dismemberment Benefit and/or the Survivor Income Benefit as shown in the benefit.] 1  
2

**LTD (non-Employer Market)**

**Claims to be Paid:** To whom All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:  
*will benefits for my claim be paid?* 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. 1

**LTD/STD**

**Claim Denial:** If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:  
*What notification will I receive if my claim is denied* 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.

**LTD/STD**

**Claim Appeal:** On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:  
*What recourse do I have if my claim is denied?* 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 1  
b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and 2  
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.

**LTD/STD**

**[Social Security:** 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:  
*When must I apply for Social Security Benefits?* 1

- 1) to follow the process established by the Social Security Administration to reconsider the denial; and

if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

**LTD/STD**

**General Provisions**

**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 .

**LTD/STD**

**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; 1
- 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.]

**LTD/STD**

**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.] 1

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

- 1) recover such overpayments from:
  - a) [You; 2
  - 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
- 3) refer Your unpaid balance to a collection agency; and
- 4) pursue and enforce all legal and equitable rights in court.

**LTD/STD**

## General Provisions

<b>Subrogation:</b> <i>What are the Company's subrogation rights?</i>	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.	1
<b>Reimbursement:</b> <i>What are the Company's Reimbursement Rights?</i>	<b>LTD/STD</b> 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.	
<b>Legal Actions:</b> <i>When can legal action be taken against Us?</i>	<b>LTD/STD</b> 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.	1 2, 3
<b>Fraud:</b> <i>How does the Company deal with fraud?</i>	<b>LTD/STD</b> 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.	1 2 3
<b>Misstatements:</b> <i>What happens if facts are misstated?</i>	<b>LTD/STD</b> 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.]	1
<b>Policy Interpretation:</b> <i>Who interprets the terms and conditions of The Policy?</i>	<b>LTD/STD</b> 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).	
<b>Physical Examinations and Autopsy:</b> <i>Will I be examined during</i>	<b>LTD/STD</b> While a claim is pending [We have the right at Our expense: 1) to have the person who has a loss examined by a Physician when and as often as We feel is necessary; and 2) to make an autopsy in case of death where it is not forbidden by law.]	1

## General Provisions

*the course of my  
claim?*

**Assignment:** *Can  
I assign benefits  
to someone under  
the Policy?*

### **LTD (non-Employer Market)**

[You have the right to absolutely assign Your rights and interest under The Policy. We will recognize 1 any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

You do not have the right to collaterally assign Your rights and interest under The Policy.]

### **LTD (non-Employer Market)**

**[Rider Language]** This rider forms a part of [The Policy to which it is attached] and [all] certificates given in connection with 1, 2, 3  
The Policy.

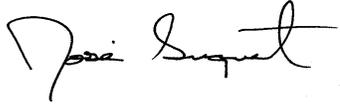
This rider becomes effective [on the later to occur of: 4

- a) the effective date of the Policy or certificate to which this rider is attached; or
- b) the first day of the month on or next following the date e accept Your application and required premium.]

[In consideration of the required additional premium and submission of satisfactory evidence of insurability, the following 5  
benefit is added to The Policy and certificates:]

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

Signed for Pan-American Life Insurance Company



[José S. Suquet ]  
[Chairman of the Board]

[ 6

] ]

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**LTD/STD**

**APPLICATION FOR  
GROUP [LTD/STD]  
INSURANCE**

**PAN-AMERICAN LIFE INSURANCE  
COMPANY  
[601 POYDRAS STREET  
NEW ORLEANS, LOUISIANA]**

1. Legal Name of Policyholder	
2. Address of Policyholder	
3. Names of Subsidiaries, Divisions, or Affiliates to be Covered	
4. Nature of Business	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>GROUP SHORT TERM DISABILITY</b> <input type="checkbox"/> Voluntary <input type="checkbox"/> Employer Paid [or/and Employee Paid]	
5. Effective Date 12:01 a.m. ____ Month ____ Day ____ Year	6. \$ _____ Deposit to Apply to Initial Premium
20. Number of Employees Eligible _____ Enrolled _____	20. Will Employees Contribute Toward Cost? <input type="checkbox"/> Yes If Yes, EE Percentage ____% <input type="checkbox"/> No
9. Eligible Classes	
10. Waiting Period A. Present Employees _____ B. Future Employees _____	
11. Amount of Insurance A. <input type="checkbox"/> Benefit Percentage: _____% Percentage is: Gross Monthly Earnings _____ Weekly earnings _____ <input type="checkbox"/> Amount elected by Insured B. Maximum Payment Amount: \$ _____	12. Maximum Payment Duration _____ Weeks
20. Benefits Commence _____ Days if Disability is due to an Accident _____ Days if Disability is due to Sickness  Or end of sick leave, whichever is greater: <input type="checkbox"/> Yes <input type="checkbox"/> No  First Day Hospital Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Basic Monthly Earnings Will Include? Commissions <input type="checkbox"/> Yes <input type="checkbox"/> No

<p><b>20. Definition of Disability</b></p> <p><input type="checkbox"/> Total Disability</p> <p><input type="checkbox"/> Residual Disability</p>	<p><b>16. Social Security Integration</b></p> <p>A. <input type="checkbox"/> Primary Social Security</p> <p>B. <input type="checkbox"/> Primary and Family Social Security</p> <p>C. <input type="checkbox"/> Other _____</p>
<p><b>20. Is This a Replacement of Similar Coverage?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p><b>18. Previous Company's Name</b></p>	
<p><b>19. Termination Date of Prior Plan</b></p>	
<p><b>20. Other</b></p>	
<p><b>[ <input type="checkbox"/> Yes <input type="checkbox"/> No ] GROUP LONG TERM DISABILITY</b></p>	
<p><b>21. Effective Date 12:01 a.m.</b></p> <p>_____ Month _____ Day _____ Year</p>	<p><b>22. \$_____ Deposit to Apply to Initial Premium</b></p>
<p><b>23. Number of Employees</b></p> <p>Eligible _____</p> <p>Enrolled _____</p>	<p><b>24. Will Employees Contribute Toward Cost?</b></p> <p><input type="checkbox"/> Yes If Yes, EE Percentage _____%</p> <p><input type="checkbox"/> No</p>
<p><b>25. Eligible Classes</b></p>	
<p><b>26. Waiting Period</b></p> <p>A. Present Employees _____</p> <p>B. Future Employees _____</p>	
<p><b>27. Pre-existing Conditions</b></p> <p><input type="checkbox"/> 3/6/12 Exclusion                      <input type="checkbox"/> 12/6/24 Exclusion                      <input type="checkbox"/> Other</p>	
<p><b>28. Disability Definition</b></p> <p>A. How will "Disability" be defined during the Elimination Period?</p> <p>i. <input type="checkbox"/> Loss of Duties</p> <p>ii. <input type="checkbox"/> Loss of Duties and Earnings</p> <p>B. How long will Own Occupation definition apply?</p> <p>i. <input type="checkbox"/> 24 Months</p> <p>ii. <input type="checkbox"/> Entire Benefit Duration</p> <p>iii. <input type="checkbox"/> Other (specify period) _____</p>	
<p><b>29. Elimination Period</b></p> <p>_____ Days</p>	<p><b>30. Basic Monthly Earnings Will Include?</b></p> <p>Commissions <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>31. Amount of Insurance</b></p> <p><input type="checkbox"/> _____ % of Basic Monthly Earnings not to exceed a Maximum Monthly Benefit of \$_____.</p> <p><input type="checkbox"/> An amount elected by the Insured in increments of \$_____</p>	

<b>33. Benefit Duration</b> <input type="checkbox"/> A. Social Security Normal Retirement Age <input type="checkbox"/> D. To Age 70 <input type="checkbox"/> B. Reducing Benefit Duration <input type="checkbox"/> E. Other _____ <input type="checkbox"/> C. 65/5/70	
<b>34. Will a Mental Illness Limitation Apply?</b> <input type="checkbox"/> Yes _____ Months <input type="checkbox"/> No	<b>35. Will a Drug and Alcohol Limitation Apply?</b> <input type="checkbox"/> Yes _____ Months <input type="checkbox"/> No
<b>36. Will the Cost of Living Adjustment Benefit be Included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Adjustment Duration Option <input type="checkbox"/> A. Maximum Benefit duration <input type="checkbox"/> B. 5 Adjustments <input type="checkbox"/> C. 10 Adjustments Adjustment Percentage: <input type="checkbox"/> A. Lesser of ½ CPI or _____% <input type="checkbox"/> B. Full CPI <input type="checkbox"/> C. Flat percentage _____%	
<b>37. Will the Survivor Income Benefit be Included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Benefit Amount: _____ times Gross Monthly Benefit (Lump Sum)	
<b>38. Is This a Replacement of Similar Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>39. Previous Company's Name</b>	
<b>40. Termination Date of Prior Plan</b>	
<b>41. Other</b>	
<b>42. For the employees to be covered under this policy, are you as the Applicant:</b> A. Contributing to Social Security for these employees? Yes <input type="checkbox"/> No <input type="checkbox"/> B. Insuring these employees under Workers Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/> C. Providing a retirement plan for these employees? Yes <input type="checkbox"/> No <input type="checkbox"/> D. Providing benefits under any other Short Term Disability, Long Term Disability, and/or Sick Leave Plan? Yes <input type="checkbox"/> No <input type="checkbox"/> [If Yes, include a description of the plan(s).]	
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.  <b>Employer (herein referred to as "We") Responsibilities under this Plan:</b> We agree: (1) to maintain the records necessary to the administration of the Policies; (2) report additions, changes, terminations and other information necessary to the administration of the Policies to the Insurer within 30 days after the effective date of such additions, changes and terminations; (3) agree that if we do not notify the Insurer of any insured ineligibility or termination within 30 days, we shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the Insurer available upon request to the Insurer or its authorized representative; (5) notify the Insurer of claims within 20 days after they are incurred; (6) pay all premiums in accordance with the terms of this Agreement; and (7) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate premium.	

It is understood and agreed that this application shall be made a part of the policy applied for and that no insurance shall be effective until approved by the Company at its home office.	Signature
	Title

Signature of Witness		For: Name of Applicant
Agent or Broker	Agent or Broker Number with PALIC	Dated at
Licensed Resident Agent (IN, NE, NC)	Lic. No.(s)	Date
Licensed Agent (Florida)		

**NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER**

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- ◆ Information we receive from you in applications or other forms;
- ◆ Information about your transactions with us, our affiliates or others; and
- ◆ Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

SERFF Tracking Number: HARP-126894538 State: Arkansas  
 Filing Company: Pan-American Life Insurance Company State Tracking Number: 47277  
 Company Tracking Number: PAL001  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
 Product Name: Group Disability Income  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification</p> <p><b>Comments:</b></p> <p><b>Attachments:</b>            IMPORTANT NOTICE AR.pdf            CERTIFICATION OF READABILITY_AR.pdf            Reg 19 Compliance Certification.pdf</p>	Approved-Closed	11/22/2010
<p><b>Satisfied - Item:</b> Application</p> <p><b>Comments:</b>            The group application is included under the Form Schedule tab.</p>	Approved-Closed	11/22/2010
<p><b>Satisfied - Item:</b> Third Party Filing Authorization</p> <p><b>Comments:</b>            We are submitting this filing on behalf of Pan-American Life Insurance Company.</p> <p><b>Attachment:</b>            PALIC Customer Agreement.pdf</p>	Approved-Closed	11/22/2010



**IMPORTANT NOTICE**

**ARKANSAS INSURED'S ACCESS TO INSURER INFORMATION**

This notice is to comply with Arkansas House Bill 1221. We are required by law to notify you of the complete addresses and phone number of the Arkansas Insurance Department, the insurance company's servicing office, and the agent. Below is this information:

Arkansas Insurance Department  
Consumer Services Division  
[1200 W. Third Street  
Little Rock, AR 72201-1904  
Telephone: 1-800-852-5494]

Servicing Office:  
[Pan American Life Insurance Company  
P.O. Box 60003  
New Orleans, LA 70160-0003  
Telephone: 1-877-939-4550 ]

Agent:  
[Name:  
Address:  
Telephone:]



**CERTIFICATION OF READABILITY**

Certification of Readability for forms PAL-DI-10-P et al.

PAL-DI-10-P: 40.9  
PAL-DI-10-C-AR: 40.0  
PAL-DI-10-APP: 40.8

We hereby certify that the above mentioned forms meet the minimum Flesch Reading Ease Base Score.



---

Michelle L. Kunzman  
AVP & Actuary  
Hartford Life and Accident Insurance Company

November 9, 2010

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Date

**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

Company: Pan-American Life Insurance Company

Forms:

PAL-DI-10-P

PAL-DI-10-C-AR

PAL-DI-10-APP

I hereby certify that to the best of my knowledge and belief, the aforementioned form submission meets the requirements of Arkansas Regulation 19 as well as all other applicable requirements of the Insurance Department of the state of Arkansas.



---

Michelle L. Kunzman  
AVP & Actuary  
Hartford Life & Accident Insurance Company  
Date: November 9, 2010

**CUSTOMER AGREEMENT**

This Customer Agreement is made and entered into this 1st day of February, 2010 by and between Hartford Life and Accident Insurance Company, a Connecticut corporation ("Contractor") and Pan-American Life Insurance Company, a Louisiana corporation ("Insurer").

**WHEREAS**, Contractor and Insurer have entered into a Consulting Services Agreement effective February 1, 2010 ("CSA") under which Contractor shall provide rate and form filing services on behalf of Insurer ("Third Party Filer Services"); and

**WHEREAS**, Contractor has entered into an agreement with the National Association of Insurance Commissioners (the "NAIC") under which the NAIC granted Contractor access to and use of the NAIC's electronic rate and form filing product, known as the System for Electronic Rate and Form Filing ("SERFF") to assist Contractor in providing Third Party Filer Services ("Third Party Filer License Agreement"); and

**WHEREAS**, prior to providing information from SERFF, Contractor and Insurer must enter into this Customer Agreement;

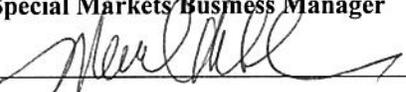
**NOW, THEREFORE**, in consideration of the mutual promises contained herein, the parties hereby agree as follows:

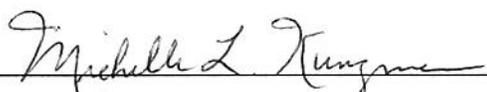
1. The above written recitals are true and accurate.
2. Neither Contractor nor the NAIC make any representation or warranty with respect to the SERFF product or the truth, accuracy, currency or completeness of the data in the SERFF product.
3. Neither Contractor nor the NAIC make any representations or warranties regarding the SERFF product which extend beyond the description of the SERFF product, including, without limitation, the implied warranties of merchantability and fitness for a particular purpose.
4. Insurer will not offer, sell or otherwise distribute all or any portion of the information from the SERFF product to any third party (defined as one who is not an officer, director, agent, consultant, contractor, employee, majority-owned subsidiary or affiliate of customer).
5. Insurer may share the information from the SERFF product with any of its subsidiaries or affiliates provided it discloses to Contractor the name and location of said subsidiaries and affiliates.
6. Insurer recognizes the SERFF product is the exclusive property of the NAIC and agrees to take no action adverse to such rights of the NAIC as owner and sole copyright proprietor.
7. Insurer agrees to keep all terms of this Customer Agreement confidential including pricing.

**IN WITNESS WHEREOF**, the parties have executed this Customer Agreement as of the date first above-written.

**PAN-AMERICAN LIFE INSURANCE COMPANY**  
By Risk Solution Resources, LLC  
Its Special Markets Business Manager

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

By: 

By: 

Name: Michael Meloch

Name: Michelle L. Kunzman

Its: CEO

Its: AVP - Actuary

Date: 2/26/10

Date: 3/4/10

*SERFF Tracking Number:*     *HARP-126894538*                             *State:*                             *Arkansas*  
*Filing Company:*             *Pan-American Life Insurance Company*     *State Tracking Number:*     *47277*  
*Company Tracking Number:*     *PAL001*  
*TOI:*                             *H11G Group Health - Disability Income*     *Sub-TOI:*                             *H11G.005 Combined Short Term and Long Term*  
*Product Name:*                 *Group Disability Income*  
*Project Name/Number:*         /

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
11/08/2010	Form	Group Application	11/22/2010	Final LTD STD Master Application.pdf (Superseded)

**APPLICATION FOR  
GROUP [LTD/STD]  
INSURANCE**

**PAN-AMERICAN LIFE INSURANCE  
COMPANY  
[601 POYDRAS STREET  
NEW ORLEANS, LOUISIANA]**

1. Legal Name of Policyholder	
2. Address of Policyholder	
3. Names of Subsidiaries, Divisions, or Affiliates to be Covered	
4. Nature of Business	
<p><b>[<input type="checkbox"/> Yes <input type="checkbox"/> No GROUP SHORT TERM DISABILITY</b></p> <p style="margin-left: 40px;"><input type="checkbox"/> Voluntary</p> <p style="margin-left: 40px;"><input type="checkbox"/> Employer Paid [or/and Employee Paid]</p>	
5. Effective Date 12:01 a.m.  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>____ Month</span> <span>____ Day</span> <span>____ Year</span> </div>	6. \$ _____ Deposit to Apply to Initial Premium
20. Number of Employees Eligible _____ Enrolled _____	20. Will Employees Contribute Toward Cost? <input type="checkbox"/> Yes If Yes, EE Percentage ____% <input type="checkbox"/> No
9. Eligible Classes	
10. Waiting Period A. Present Employees _____ B. Future Employees _____	
11. Amount of Insurance A. <input type="checkbox"/> Benefit Percentage: _____% <i>Percentage is: Gross Monthly Earnings _____</i> <i>Weekly earnings _____</i> <input type="checkbox"/> Amount elected by Insured B. Maximum Payment Amount: \$ _____	12. Maximum Payment Duration _____ Weeks
20. Benefits Commence _____ Days if Disability is due to an Accident _____ Days if Disability is due to Sickness  Or end of sick leave, whichever is greater: <input type="checkbox"/> Yes <input type="checkbox"/> No  First Day Hospital Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Basic Monthly Earnings Will Include? Commissions <input type="checkbox"/> Yes <input type="checkbox"/> No

<p><b>20. Definition of Disability</b></p> <p><input type="checkbox"/> Total Disability</p> <p><input type="checkbox"/> Residual Disability</p>	<p><b>16. Social Security Integration</b></p> <p>A. <input type="checkbox"/> Primary Social Security</p> <p>B. <input type="checkbox"/> Primary and Family Social Security</p> <p>C. <input type="checkbox"/> Other _____</p>
<p><b>20. Is This a Replacement of Similar Coverage?</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p><b>18. Previous Company's Name</b></p>	
<p><b>19. Termination Date of Prior Plan</b></p>	
<p><b>20. Other</b></p>	
<p><b>[ <input type="checkbox"/> Yes <input type="checkbox"/> No GROUP LONG TERM DISABILITY ]</b></p>	
<p><b>21. Effective Date 12:01 a.m.</b></p> <p>_____ Month _____ Day _____ Year</p>	<p><b>22. \$_____ Deposit to Apply to Initial Premium</b></p>
<p><b>23. Number of Employees</b></p> <p>Eligible _____</p> <p>Enrolled _____</p>	<p><b>24. Will Employees Contribute Toward Cost?</b></p> <p><input type="checkbox"/> Yes If Yes, EE Percentage _____%</p> <p><input type="checkbox"/> No</p>
<p><b>25. Eligible Classes</b></p>	
<p><b>26. Waiting Period</b></p> <p>A. Present Employees _____</p> <p>B. Future Employees _____</p>	
<p><b>27. Pre-existing Conditions</b></p> <p><input type="checkbox"/> 3/6/12 Exclusion <input type="checkbox"/> 12/6/24 Exclusion <input type="checkbox"/> Other</p>	
<p><b>28. Disability Definition</b></p> <p>A. How will "Disability" be defined during the Elimination Period?</p> <p>i. <input type="checkbox"/> Loss of Duties</p> <p>ii. <input type="checkbox"/> Loss of Duties and Earnings</p> <p>B. How long will Own Occupation definition apply?</p> <p>i. <input type="checkbox"/> 24 Months</p> <p>ii. <input type="checkbox"/> Entire Benefit Duration</p> <p>iii. <input type="checkbox"/> Other (specify period) _____</p>	
<p><b>29. Elimination Period</b></p> <p>_____ Days</p>	<p><b>30. Basic Monthly Earnings Will Include?</b></p> <p>Commissions <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>31. Amount of Insurance</b></p> <p><input type="checkbox"/> _____ % of Basic Monthly Earnings not to exceed a Maximum Monthly Benefit of \$_____.</p> <p><input type="checkbox"/> An amount elected by the Insured in increments of \$_____</p>	

<b>33. Benefit Duration</b> <input type="checkbox"/> A. Social Security Normal Retirement Age <input type="checkbox"/> D. To Age 70 <input type="checkbox"/> B. Reducing Benefit Duration <input type="checkbox"/> E. Other _____ <input type="checkbox"/> C. 65/5/70	
<b>34. Will a Mental Illness Limitation Apply?</b> <input type="checkbox"/> Yes ____ Months <input type="checkbox"/> No	<b>35. Will a Drug and Alcohol Limitation Apply?</b> <input type="checkbox"/> Yes ____ Months <input type="checkbox"/> No
<b>36. Will the Cost of Living Adjustment Benefit be Included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Adjustment Duration Option <input type="checkbox"/> A. Maximum Benefit duration <input type="checkbox"/> B. 5 Adjustments <input type="checkbox"/> C. 10 Adjustments Adjustment Percentage: <input type="checkbox"/> A. Lesser of ½ CPI or _____% <input type="checkbox"/> B. Full CPI <input type="checkbox"/> C. Flat percentage _____%	
<b>37. Will the Survivor Income Benefit be Included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Benefit Amount: ____ times Gross Monthly Benefit (Lump Sum)	
<b>38. Is This a Replacement of Similar Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>39. Previous Company's Name</b>	
<b>40. Termination Date of Prior Plan</b>	
<b>41. Other</b>	
<b>42. For the employees to be covered under this policy, are you as the Applicant:</b> A. Contributing to Social Security for these employees? Yes <input type="checkbox"/> No <input type="checkbox"/> B. Insuring these employees under Workers Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/> C. Providing a retirement plan for these employees? Yes <input type="checkbox"/> No <input type="checkbox"/> D. Providing benefits under any other Short Term Disability, Long Term Disability, and/or Sick Leave Plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, include a description of the plan(s).]	
<p>Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.</p> <p><b>Employer (herein referred to as "We") Responsibilities under this Plan:</b>          We agree: (1) to maintain the records necessary to the administration of the Policies; (2) report additions, changes, terminations and other information necessary to the administration of the Policies to the Insurer within 30 days after the effective date of such additions, changes and terminations; (3) agree that if we do not notify the Insurer of any insured ineligibility or termination within 30 days, we shall forfeit any premium refund/credit that would otherwise have been due; (4) make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the Insurer available upon request to the Insurer or its authorized representative; (5) notify the Insurer of claims within 20 days after they are incurred; (6) pay all premiums in accordance with the terms of this Agreement; and (7) notify all employees of any termination or rescission of coverage which affects them and refund the appropriate premium.</p>	

It is understood and agreed that this application shall be made a part of the policy applied for and that no insurance shall be effective until approved by the Company at its home office.	Signature  Title
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Signature of Witness		For: Name of Applicant
Agent or Broker	Agent or Broker Number with PALIC	Dated at
Licensed Resident Agent (IN, NE, NC)	Lic. No.(s)	Date
Licensed Agent (Florida)		

**NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER**

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- ◆ Information we receive from you in applications or other forms;
- ◆ Information about your transactions with us, our affiliates or others; and
- ◆ Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.