

SERFF Tracking Number: CMTR-126727617 State: Arkansas
Filing Company: Commercial Travelers Mutual Insurance State Tracking Number: 46258
Company
Company Tracking Number: LTD2009CERT(MET)
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: LTD-MET
Project Name/Number: LTD-MET/LTD2009POL(MET)

Filing at a Glance

Company: Commercial Travelers Mutual Insurance Company

Product Name: LTD-MET

SERFF Tr Num: CMTR-126727617 State: Arkansas

TOI: H11G Group Health - Disability Income

SERFF Status: Closed-

State Tr Num: 46258

Disapproved

Sub-TOI: H11G.003 Long Term

Co Tr Num: LTD2009CERT(MET)

State Status: Disapproved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Donna Guminiak, Helena

Disposition Date: 12/30/2010

Vennette

Date Submitted: 07/20/2010

Disposition Status: Disapproved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LTD-MET

Status of Filing in Domicile:

Project Number: LTD2009POL(MET)

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

Group Market Type: Employer, Trust

Overall Rate Impact:

Filing Status Changed: 12/30/2010

State Status Changed: 12/30/2010

Deemer Date:

Created By: Helena Vennette

Submitted By: Helena Vennette

Corresponding Filing Tracking Number:

Filing Description:

MULTIPLE EMPLOYER TRUST – GROUP DISABILITY

The attached MULTIPLE EMPLOYER TRUST GROUP DISABILITY POLICY and related forms are herewith submitted for Departmental review and approval.

These forms were approved by the State of Missouri Insurance Department on April 22, 2010. Missouri is the situs of the Trust. This is a true Multiple Employer Trust and, therefore, eligible for group insurance under both Missouri and Arkansas Laws.

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The Trustee/ Policyholder will be The Commerce Trust Company, Successor Trustee of the Trust Agreement dated April 26, 1993 naming the United Missouri Bank as Trustee. A copy of the Trust Agreement and acceptance letter from The Commerce Trust Company are enclosed for your reference.

The policy and certificate will replace currently approved Group Long Term Disability Policy, Form Number 50137(POL)LTD ELITE and Group Long Term Disability Certificate, Form Number 50138(CERT) LTD ELITE previously approved by your Department on January 31, 1995 for all new issues. Existing employer plans will continue under the previously approved forms.

The currently approved policy requires at least 80% of the employees of an employer plan to be white collar employees. The new Policy doesn't have this restriction, thereby allowing us to offer our product to a larger number of small employer groups. This Policy will provide long-term disability insurance and will be marketed to small employers to provide coverage for their employees. The small employers will be those with 2-9 employees.

Company and Contact

Filing Contact Information

Donna Guminiak, Compliance Officer dguminiak@commercialtravelers.com
 70 Genesee Street 800-422-6200 [Phone] 261 [Ext]
 Utica, NY 13502 315-724-6372 [FAX]

Filing Company Information

Commercial Travelers Mutual Insurance CoCode: 81426 State of Domicile: New York
 Company
 70 Genesee Street Group Code: 560 Company Type:
 Utica, NY 13502 Group Name: State ID Number:
 (800) 422-6200 ext. [Phone] FEIN Number: 15-0274810

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 forms @ \$50 per form
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Commercial Travelers Mutual Insurance Company	\$300.00	07/20/2010	38159542

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	12/30/2010	12/30/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Rosalind Minor	08/27/2010	08/27/2010			
Industry						
Response						
Pending	Rosalind Minor	08/05/2010	08/05/2010	Helena Vennette	08/21/2010	08/21/2010
Industry						
Response						

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Product Name: LTD-MET
Project Name/Number: LTD-MET/LTD2009POL(MET)

Disposition

Disposition Date: 12/30/2010

Implementation Date:

Status: Disapproved

Comment:

This filing is being disapproved since we have not had a response to my Objection Letter of 8/27/10.

If you wish to resubmit the filing at a later date, the filing must be submitted in its entirety along with the appropriate filing fee.

Thank you for your understanding in this matter.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Trust Agreement	Disapproved	Yes
Supporting Document	Commerce Bank letter	Disapproved	Yes
Form	Group Long Term Disability Income Insurance Policy	Disapproved	Yes
Form	Group Long Term Disability Income Insurance Certificate	Disapproved	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/27/2010

Submitted Date 08/27/2010

Respond By Date

Dear Donna Guminiak,

This will acknowledge receipt of the captioned filing.

Objection 1

- Trust Agreement (Supporting Document)

Comment:

In your response to my Objection Letter, you inquired as to whether you need to register the MET again.

Under ACA 23-92-101(B), it is stated that...."After the initial registration, each fully insured multiple employer trust and fully insured multiple employer welfare arrangement under this section that conducts business in Arkansas shall thereafter register with the commissioner no later than January 1 of each year for as long as it continues to do business in Arkansas....".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/05/2010

Submitted Date 08/05/2010

Respond By Date

Dear Donna Guminiak,

This will acknowledge receipt of the captioned filing.

Objection 1

- Trust Agreement (Supporting Document)

Comment:

Before the policy can be issued to the MET as the policyholder, the MET must be registered with our License Division.

You may obtain Registration Instructions and the registration form at:

<http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TRUST, MET, MEWA.

At this point do you wish to withdraw the filing until such time as you obtain notification that the trust has been registered?

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 08/21/2010
Submitted Date 08/21/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter of August 8.

Response 1

Comments: The MET was registered and approved by them on January 31, 1995. This is a fully insured Multiple Employer Trust.

Do we need to register is again?

Related Objection 1

Applies To:

- Trust Agreement (Supporting Document)

Comment:

Before the policy can be issued to the MET as the policyholder, the MET must be registered with our License Division.

You may obtain Registration Instructions and the registration form at:

<http://www.insurance.arkansas.gov/License/forms.htm>. Scroll down to SELF, TRUST, MET, MEWA.

At this point do you wish to withdraw the filing until such time as you obtain notification that the trust has been registered?

Changed Items:

No Supporting Documents changed.

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No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,
Donna Guminiak, Helena Vennette

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Form Schedule

Lead Form Number: LTD2009CERT(MET)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved 12/30/2010	LTD2009POL(MET)(MO)	Policy/Contractual Certificate	Group Long Term Disability Income Insurance Policy	Initial		60.000	LTD2009POL(MET)(MO).pdf
Disapproved 12/30/2010	LTD2009CERT(MET)(MO)	Certificate	Group Long Term Disability Income Insurance Certificate	Initial		57.000	LTD2009CERT(MET)(MO).pdf

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POLICYHOLDER PROVISIONS

INCONTESTABILITY

The validity of an **Employer's** plan of coverage under the policy shall not be contested after the plan has been in effect for two years except in situations when:

1. premium has not been paid; or
2. for fraudulent misrepresentations.

COST OF INSURANCE

We will furnish premium rates to the **Policyholder** and the **Employer(s)** with an explanation of how they are to be applied.

INITIAL RATE GUARANTEE AND RATE CHANGES

We may change the premium rates:

1. at any time on or after the first anniversary of an **Employer's** Plan Effective Date ; and
2. on any date when **our** liability under the policy or **Employer's** plan is changed.

We will notify the **Employer** in writing at least 31 days before a premium rate is changed. A change may take effect on an earlier date when both the **Employer** and **we** agree.

WHEN PREMIUM IS DUE

The first premium for an **Employer's** plan is due on the Plan Effective Date. Future premiums will be due on each premium due date after that.

The **Employer(s)** must send all premiums to **us** on or before their respective due date. The premium must be paid in United States dollars.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases which take effect during a month are adjusted and due on the next premium due date following the change. Changes will be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

We will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WAIVER OF PREMIUM

We do not require premium payment while the **insured person** is receiving Long Term Disability payments under this policy.

INFORMATION REQUIRED FROM THE EMPLOYER

The **Employer** must provide **us** with the following on a regular basis:

1. information about persons:
 - a. who are eligible to become insured; an
 - b. who **enroll** for coverage and their initial amount of coverage;
 - c. whose amounts of coverage change; and
 - d. whose coverage ends;
2. occupational and salary information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Employer records that have a bearing, in **our** opinion, on the coverage provided by this policy will be available for review by **us** at any reasonable time as determined by **us**.

INFORMATION PROVIDED BY US

We will furnish the **Employer(s)** with a Certificate of Coverage which outline the benefits under this policy. The **Employer(s)** will make available a Certificate of Coverage to **insured persons**.

CANCELING THE POLICY

We may cancel this policy at any time after the first anniversary date, except for nonpayment of required premium, by giving at least 31 days advance written notice of termination to the **Policyholder** and the **Employer(s)**.

If this policy is canceled, the cancellation will not affect a **payable claim**.

AMENDING OR CANCELING AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY

An **Employer's** plan of coverage can be canceled:

1. by **us**; or
2. by the **Employer**.

We may amend or cancel an **Employer's** plan of coverage under this policy if:

1. there is less than 100% participation of those eligible persons working for an Employer with 2 to 5 eligible persons;
2. the participation requirement is not met for an **Employer** with 6 to 9 eligible persons who pay a part of their premium for the policy:

<u>Eligible Persons</u>	<u>Participation Requirement</u>
6	5 enrolled
7	6 enrolled
8	6 enrolled
9	7 enrolled

3. the **Employer** does not promptly provide **us** with information that is reasonably required;
4. the **Employer** fails to perform any of its obligations that relate to the Employer's plan of coverage under this policy;
5. fewer than 2 persons are insured under an **Employer's** plan of coverage under this policy;
6. **we** determine that there is a significant change, in the size, occupation or age of the eligible class(es); or
7. the **Employer** fails to pay any portion of the premium within the 31 day **grace period**.

If **we** amend or cancel an **Employer's** plan of coverage under the policy for reasons other than the **Employer's** failure to pay premiums, written notice will be mailed to the **Employer** at least 31 days prior to the amendment date or cancellation date. The **Employer** may cancel the **Employer's** plan of coverage under the policy if the amendments are unacceptable.

If any portion of the premium is not paid during the **grace period**, the **Employer's** plan of coverage under this policy will terminate automatically at the end of the **grace period**. The **Employer** is liable for premium for coverage during the **grace period**. The **Employer** must pay **us** all premium due for the full period the **Employer's** coverage under this policy is in force.

The **Employer** may cancel the **Employer's** plan of coverage under the policy by providing written notice to **us** at least 31 days prior to the cancellation date. When both the **Employer** and **we** agree, the **Employer's** plan of coverage under the policy can be canceled on an earlier date. If **we** or the **Employer** cancel an **Employer's** plan of coverage under the policy, coverage will end at 12:00 midnight Standard Time at the **Policyholder's** address on the last day of coverage.

If an **Employer's** plan of coverage under the policy is canceled, the cancellation will not affect a **payable claim**.

**GROUP LONG TERM DISABILITY INCOME INSURANCE CERTIFICATE
NON-PARTICIPATING**

POLICYHOLDER: Trustee of the Multiple Employer Group Insurance Trust

POLICY NUMBER: []

EMPLOYER: [ABC, INC.]

PLAN EFFECTIVE DATE: [MM/DD/YYYY]

INSURED: [JANE DOE]

CERTIFICATE NUMBER: []

INSURED'S EFFECTIVE DATE: [MM/DD/YYYY]

GOVERNING JURISDICTION: Missouri

Commercial Travelers Mutual Insurance Company (referred to as Commercial Travelers) welcomes **you** as a certificate holder.

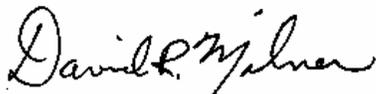
This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

We have written **your** Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance **law**. If **you** have any questions about any of the terms and provisions, please consult **our** claims paying office. **We** will assist **you** in any way to help **you** understand **your** benefits.

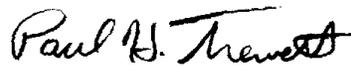
If the terms and provisions of the Certificate of Coverage (issued to **you**) are different from the policy (issued to the **Policyholder**), the policy will govern. **Your** coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the **Policyholder's** address and end at 12:00 midnight Standard Time at the **Policyholder's** address.

Commercial Travelers Mutual Insurance Company
Commercial Travelers Building
70 Genesee Street
Utica, New York 13502



Secretary



President

The policy covers disabilities due to an occupational sickness or injury.

The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

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(The Participating Employer will select from the options available under the policy)

BENEFITS AT A GLANCE LONG TERM DISABILITY

The Long Term Disability policy provides financial protection for **you** by paying a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

ELIGIBLE CLASS(ES):

[All **employees**] in **active employment** in the United States with the **Employer**.

You must be an **employee** of the **Employer** and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT:

30 hours per week

WAITING PERIOD:

For persons in an eligible class on or before the Plan Effective date: A continuous period of 30 days of **active employment**.

For persons entering an eligible class after the Plan Effective date: A continuous period of 30 days of **active employment**.

REHIRE:

If **your** employment ends and **you** are rehired within 12 months, **your** previous work while in an eligible class will apply toward the **waiting period**. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

[**Your Employer** pays the cost of **your** coverage.]

[**You** and **your Employer** share the cost of **your** coverage.]

[**You** pay the cost of **your** coverage.]

WAIVER OF PREMIUM:

We do not require premium payments for **your** coverage while **you** are receiving or are entitled to receive Long Term Disability payments under the policy.

ACCUMULATION OF ELIMINATION PERIOD:

Elimination period: [90, 180] consecutive days.

Accumulation period: [180, 360] consecutive days.

The elimination period and the accumulation period begin on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

MONTHLY BENEFIT:

[50% - 66.7%] of **monthly earnings** to a **maximum benefit** of [\$4,000- \$7,500] per month.

Your benefit may be reduced by any **deductible sources of income** and **disability earnings**. Some disabilities may not be covered or may have limited coverage under the policy.

[MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY:

[\$2,000 - \$6,000] per month]

MONTHLY EARNINGS:

(Current Income Before Taxes, Including Deferred Compensation)

["**Monthly Earnings**" means **your** gross monthly income from **your Employer** in effect just prior to **your** date of disability. It includes **your** total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than **your Employer**.

[**Monthly earnings** will be averaged for the lesser of:

- a) the 12 full calendar months period of **your** employment with **your Employer** just prior to the date **your** disability begins; or
- b) the period of actual employment with **your Employer**]

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the **monthly payment.**]

MAXIMUM PERIOD OF PAYMENT:

(ADEA – 65 Reducing Benefit Duration (RBD))

<u>Age When Disability Begins</u>	<u>Maximum Period of Payment</u>
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

(5 Years RBD)

<u>Age When Disability Begins</u>	<u>Maximum Period of Payment</u>
Less than age 61	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months]

(2 Years RBD)

[Age When Disability Begins

Less than age 66

Age 66

Age 67

Age 68

Age 69 and over

Maximum Period of Payment

24 months

21 months

18 months

15 months

12 months]

[REGULAR OCCUPATION PERIOD:

36 Months]

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

DEFINITIONS

ACTIVE EMPLOYMENT means **you** are working for **your Employer** for earnings that are paid regularly and that **you** are performing the **material and substantial duties** of **your regular occupation**. **You** must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.

To be in **active employment**, **your** work site must be:

1. **your Employer's** usual place of business; or
2. an alternative work site at the direction of **your Employer**, including **your** home; or
3. a location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment**.

Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that **you**:

1. visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s); and
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize **your** disabling condition including having corrective treatment or minor surgery.

CONTEST means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** assert in writing that such coverage was therefore never effective. The contest is effective on the date **we** mail the letter along with a refund of premium.

DEDUCTIBLE SOURCES OF INCOME means income from other sources as listed in the policy which **you** receive or are eligible to receive while **you** are disabled. This income will be subtracted from **your gross monthly payment**.

DISABILITY EARNINGS means the earnings which **you** receive while **you** are disabled and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

DOCTOR means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the **laws** and regulations of the governing jurisdiction.

We will not recognize **you** or **your** family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as a **doctor** for a claim that **you** send to **us**.

EFFECTIVE DATE means the date set forth in the Policy. The date shown in your Certificate will be the **Effective Date** of coverage for you. . The **Effective Date** of the Plan will be the first date any **Employee** of the Employer becomes insured under the Policy.

ELIGIBLE SURVIVOR means **your** spouse, if living; otherwise, **your** children under age 25.

EMPLOYEE means a person who is a citizen or legal resident of the United States in **active employment** with the **Employer** in the United States.

EMPLOYER means the Participating Employer who has applied for and has been accepted by **us** for coverage under the policy, and who subscribes to the Multiple Employer Group Insurance Trust. The Employer will be named on each Certificate.

ENROLL means **you** have completed the process of applying for coverage under the policy.

ENROLLMENT FORM means the application **you** complete and submit to **us** to apply for coverage under the policy.

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage. **Evidence of insurability** will be provided at **your** own expense.

EVIDENCE OF INSURABILITY FORM means the portion of the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history.

[GAINFUL OCCUPATION means an occupation that is or can be expected to provide **you** with an income within 12 months of **your** return to work, that exceeds:

80% of **your indexed monthly earnings**, if **you** are working;

60% of **your indexed monthly earnings**, if **you** are not working.]

GRACE PERIOD means the 31 day period following the premium due date during which premium payment may be made.

GROSS MONTHLY PAYMENT means **your** benefit before any reduction for **deductible sources of income** and **disability earnings**.

HOSPITAL, HEALTH FACILITY OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing **your** disability.

INDEXED MONTHLY EARNINGS means **your monthly earnings** adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. **Your indexed monthly earnings** may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. **We** reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are disabled and working and in the determination of **gainful occupation**.

INJURY means a bodily **injury** that is the direct result of an **accident** and not related to any other cause. The **injury** must occur, and disability resulting from the **injury** must begin while **you** are covered under the policy. **Injury** that occurs before **you** are covered under the policy will be treated as a **sickness**.

INSURED means any person covered under the policy.

INSURED PERSON means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

LAW, PLAN, or ACT means the original enactments of the law, plan, or act and all amendments.

LEAVE OF ABSENCE means **you** are absent from **active employment** for a period of time that has been agreed to in advance in writing by **your Employer**.

Your normal vacation time or any period of disability is not considered a **leave of absence**.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

1. are normally required for the performance of **your regular occupation**; and
2. cannot be reasonably omitted or modified, except that if **you** are required to work on average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** have the capacity to work 40 hours per week.

MAXIMUM BENEFIT means the total monthly benefit amount for which **you** are insured under the policy subject to all policy provisions.

(For RBD and 5 Years/RBD benefit durations)

[MAXIMUM CAPACITY means, based on **your** restrictions and limitations:

1. during the **regular occupation period**, the greatest extent of work **you** are able to do in **your regular occupation**; and
2. beyond the **regular occupation period**, the greatest extent of work **you** are able to do in any occupation for which **you** are reasonably fitted by education, training or experience.]

(For 2 Years/RBD benefit duration)

[MAXIMUM CAPACITY means, based on **your** restrictions and limitations, the greatest extent of work **you** are able to do in **your regular occupation**.]

MAXIMUM PERIOD OF PAYMENT means the longest period of time **we** will make payments to **you** for any one period of disability.]

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY EARNINGS means **your** gross monthly income from **your Employer** as stated in the BENEFITS AT A GLANCE.

MONTHLY PAYMENT means **your** benefit after any **deductible sources of income** and **disability earnings** have been subtracted from **your gross monthly payment**.

OCCUPATIONAL SICKNESS OR INJURY means a **sickness** or **injury** that was caused by or aggravated by any employment for pay or profit.

PART- TIME BASIS means the ability to work and earn from 20% through 80% of **your indexed monthly earnings**. Ability is based on capacity and not market availability.

PAYABLE CLAIM means a claim for which **we** are liable under the terms of the policy.

POLICYHOLDER means the Trustee of the Multiple Employer Group Insurance Trust.

PRE-EXISTING CONDITION means any condition for which **you** have done any of the following at any time during the [3-12] months just prior to **your** effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures.

RECURRENT DISABILITY means a disability which is:

1. caused by a worsening in **your** condition; and
2. due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment**.

REGULAR OCCUPATION means the occupation **you** are routinely performing when **your** disability begins. **We** will look at **your** occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

[REGULAR OCCUPATION PERIOD is the period of time shown in the BENEFITS AT A GLANCE that begins after the elimination period.]

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to **employees** and are not funded entirely by **employee** contributions. **Retirement plan** includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

SALARY CONTINUATION or **ACCUMULATED SICK LEAVE** means continued payments to **you** by **your Employer** of all or part of **your monthly earnings**, after **you** become disabled as defined by the policy. This continued payment must be part of an established plan maintained by **your Employer**, and includes **salary continuation, accumulated sick leave** or any similar **Employer** sponsored paid time off plan.

SICKNESS means illness, disease or physical condition. Disability resulting from the **sickness** must begin while **you** are covered under the policy.

[TREATMENT FREE means **you** have not received medical treatment, consultation, care or services including diagnostic measures, and **you** have not taken or been prescribed drugs or medicines for the **pre-existing condition.**]

WAITING PERIOD means the continuous period of time (shown in the **BENEFITS AT A GLANCE**) that **you** must be in **active employment** in an eligible class before **you** are eligible for coverage under the policy.

WE, US, and OUR means Commercial Travelers Mutual Insurance Company.

YOU and YOUR means a person who is eligible for coverage under the policy.

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include attachments. It tells **you**:

1. the coverage to which **you** may be entitled;
2. to whom **we** will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of:

1. the effective date of **your Employer's** plan of coverage under the policy; or
2. the day after **you** complete **your waiting period**.

WHEN COVERAGE BEGINS

[When **your Employer** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. Standard Time at the **Policyholder's** address on the date **you** are eligible for coverage.

When **you** and **your Employer** share the cost of **your** coverage under the policy or when **you** pay 100% of the cost yourself, **you** will be covered at 12:01 a.m. Standard Time at the **Policyholder's** address on the latest of:

1. the date **you** are eligible for coverage, if **you enroll** for insurance on or before that date;
2. the first day of the month following the date **you enroll** for insurance, if **you enroll** within 31 days after the date **you** become eligible for coverage; or
3. the first day of the month following the date **we** approve **your enrollment form**, if **evidence of insurability** is required.

In order for **your** coverage to begin, **you** must be in **active employment**. **Your** coverage is subject to payment of premium.]

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment**. If **you** are not in **active employment** due to **injury** or **sickness**, any increased or additional coverage will begin on the date **you** return to **active employment**.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of Insurability is required if:

1. **you** are a late applicant, which means **you enroll** for coverage more than 31 days after the date **you** are eligible for coverage;
2. **you** voluntarily canceled **your** coverage and are reapplying[.]; or
3. **you** apply for a monthly benefit amount greater than the MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY as shown in the BENEFITS AT A GLANCE, when **you** first become eligible for coverage under the policy.]

An **evidence of insurability form** can be obtained from **your Employer**.

IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence**, and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment**, limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of disability coverage during an FMLA or State FML **leave of absence**, **your** coverage will be continued until the end of the later of:

1. the leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments; or
2. the leave period permitted by applicable state **law**.

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if premium is paid, **your** coverage will be continued through the end of the month that immediately follows the date on which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law**, **your** coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence**; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence**.

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment**, **we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence**, and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence**, **your** coverage will be reinstated. **We** will not apply a new **waiting period**, require **evidence of insurability**, or apply a new **pre-existing condition** limitation.

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment**, **your** coverage may be reinstated in accordance with USERRA and applicable state **law**.

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled;
2. the date **your Employer's** plan of coverage under the policy is canceled;
3. the date **you** are no longer in an eligible class;
4. the date **your** eligible class is no longer covered;
5. the end of the period for which **you** paid premiums, if **you** stop making a required premium contribution;
6. the end of the Employer's [31 day] **grace period**, if the Employer does not remit premium to **us** by the end of such period; or
7. the last day **you** are in **active employment** except as provided under a covered **leave of absence**.

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy.

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding **your** claim 60 days after proof of claim has been given to **us**, and up to three years from the time proof of claim is required, unless otherwise provided under federal **law**.

STATEMENTS MADE IN AN APPLICATION FOR COVERAGE

We consider any statements **you** or **your Employer** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless:

1. the statement is in writing and is signed by **you**; and
2. a copy of that statement is given to **you** or **your** beneficiary.

TIME LIMIT ON CERTAIN DEFENSES

Except in the case of fraud, no statement made by **you** relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

CLERICAL ERROR

Clerical error or omission by **us** or **your Employer** will not:

1. prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy; or
2. cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

If the **Employer** gives **us** information about **you** that is incorrect, **we** will:

1. use the facts to decide whether **you** have coverage under the policy and in what amounts; and
2. make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums applicable to **you** are based on age and **you** have misstated **your** age, there will be a fair adjustment of premiums based on **your** true age. If the benefits applicable to **you** are based on age and **you** have misstated **your** age, there will be an adjustment of said benefits based on **your** true age. **We** may require satisfactory proof of **your** age before paying any claim.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy and **your Employer's** plan of coverage under the policy, the **Employer** acts on its own behalf or as **your** agent. Under no circumstances will the **Employer** be deemed **our** agent.

LONG TERM DISABILITY BENEFIT INFORMATION

DEFINITION OF DISABILITY

(For RBD and 5 Years/RBD benefit durations)

[You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**:

1. **you** are unable to perform all the **material and substantial duties** of **your regular occupation**;
2. **you** have a 20% or more loss in **your indexed monthly earnings**; and
3. during the elimination period, **you** are unable to perform any of the **material and substantial duties** of **your regular occupation**, and **you** are not working in any occupation.

After the **regular occupation period**, **you** are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**, **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.]

(2 years/RBD Duration)

[You are considered disabled when **we** review **your** claim and determine that due to **your sickness** or **injury**:

1. **you** are unable to perform all the **material and substantial duties** of **your regular occupation**;
2. **you** have a 20% or more loss in **your indexed monthly earnings**; and
3. during the elimination period, **you** are unable to perform any of the **material and substantial duties** of **your regular occupation**, and **you** are not working in any occupation.]

(For all plans)

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

We may require **you** to be examined by one or more **doctors**, other medical practitioners, or vocational experts of **our** choice. **We** will pay for this examination. **We** can require an examination as often as it is reasonable to do so. **We** may also require **you** to be interviewed by **our** authorized representative. **Your** failure to comply with this request may result in denial or termination of benefits.

ACCUMULATION OF ELIMINATION PERIOD

You must be continuously disabled through **your** elimination period. **Your** elimination period is as stated in the BENEFITS AT A GLANCE and is the period of continuous disability **you** must satisfy before **you** are eligible to receive benefits under the policy.

If **you** return to work while satisfying **your** elimination period, **you** may satisfy **your** elimination period within the accumulation period. The accumulation period is as stated in the BENEFITS AT A GLANCE.

The days that **you** are not disabled will not count toward **your** elimination period.

If **you** do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

The elimination period and the accumulation period begin on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when **we** approve **your** claim, providing the elimination period has been met and **you** are disabled, and **you** are under the **appropriate care** of a **doctor**. **We** will send **you** a **monthly payment** at the end of each month for any period for which **we** are liable.

After the elimination period, if **you** are disabled for less than 1 month, **we** will send **you** 1/30th of **your monthly payment** for each day of **your** disability.

AMOUNT OF PAYMENT

A. IF YOU ARE DISABLED AND NOT WORKING , OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS

We will follow this process to figure **your** payment:

1. Multiply **your monthly earnings** by [50% - 66.7%].
2. The **maximum benefit** is [\$4,000 - \$7,500] per month.
3. Compare the answer from Item 1 with the **maximum benefit**. The lesser of these two amounts is **your gross monthly payment**.
4. Subtract from **your gross monthly payment** any **deductible sources of income**.

The amount figured in Item 4 is **your monthly payment**.

B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR INDEXED MONTHLY EARNINGS

During the first 12 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings**. If the sum exceeds 100% of **your indexed monthly earnings**, **we** will reduce **your** payment under the policy by the excess amount.

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed monthly earnings**, **we** will follow this process:

1. Multiply **your monthly earnings** by [50% - 66.7%].
2. The **maximum benefit** is [\$4,000 - \$7,500] per month.
3. Compare the answer from Item 1 with the **maximum benefit**. The lesser of these two amounts is **your gross monthly payment**.
4. Add **your disability earnings** to **your gross monthly payment**.

If the answer in Item 4 above is less than or equal to 100% of **your indexed monthly earnings**, **your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income**.

If the answer in Item 4 above is greater than 100% of **your indexed monthly earnings**, **we** will follow this process to figure **your monthly payment**:

- a. Add **your disability earnings** to **your gross monthly payment**.
- b. From the answer in Item a, subtract **your indexed monthly earnings**. If the result is zero or less, record **your** answer as zero.
- c. From **your gross monthly payment**, subtract the answer in Item b and any **deductible sources of income**.

The amount figured in Item c is **your monthly payment**.

After 12 months of payments, **your monthly payment** will be reduced by 50% of **your disability earnings**. **We** will follow this process to determine **your monthly payment**:

1. Multiply **your disability earnings** by 50%.
2. From **your gross monthly payment**, subtract the answer in Item 1 and any **deductible sources of income**.

The answer in Item 2 is **your monthly payment**.

C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR INDEXED MONTHLY EARNINGS

If **you** are working and **your disability earnings** are more than 80% of **your indexed monthly earnings**, no benefit will be payable.

We may require **you** to send proof of **your monthly disability earnings** each month. **We** will adjust **your** payment based on **your monthly disability earnings**.

As part of **your** proof of **disability earnings**, **we** can require that **you** send **us** appropriate financial records that **we** believe are necessary to substantiate **your** income.

After the elimination period, if **you** are disabled for less than 1 month, **we** will send **you** 1/30th of **your monthly payment** for each day of disability.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If **your disability earnings** routinely fluctuate widely from month to month, **we** may average **your disability earnings** over the most recent three months to determine if **your** claim should continue.

If **we** average **your disability earnings**, **we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months exceeds 80% of **your indexed monthly earnings**.

We will not pay **you** for any month during which **your disability earnings** exceed the amount allowable under the policy. In no event will benefits be paid beyond the **maximum period of payment**.

DEDUCTIBLE SOURCES OF INCOME

The following are **deductible sources of income**:

1. The amount that **you** receive, or are eligible to receive, as disability income payments under any:
 - a. state compulsory benefit **act** or **law**;
 - b. individual disability income **plans** which are paid for by **your Employer** and purchased on or after the effective date of this policy;
 - c. automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable;
 - d. military disability benefit plan;
 - e. governmental retirement system as a result of **your** job with **your Employer**; or
 - f. other group insurance policy.
2. The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
3. The amount **you** receive under any **salary continuation** or **accumulated sick leave** plan.
4. The amount that **you**:
 - a. receive as disability payments under **your Employer's retirement plan**;
 - b. voluntarily elect to receive as retirement payments under **your Employer's retirement plan**; or
 - c. are eligible to receive as retirement payments when **you** reach the later of age 62 or normal retirement age, as defined in **your Employer's retirement plan**.

Disability payments under a **retirement plan** will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are paid based on **your Employer's** contribution to the **retirement plan**. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the **retirement plan** are distributed, **we** will consider the **Employer** and **employee** contributions to be distributed simultaneously throughout **your** lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible **retirement plan**. **We** will use the definition of eligible **retirement plan** as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

5. The amount that **you**, **your** spouse, and **your** children receive, or are eligible to receive, as disability payments because of **your** disability under:
 - a. the United States Social Security **Act**;
 - b. the Canada Pension **Plan**;
 - c. the Quebec Pension **Plan**; or
 - d. any similar **Plan** or **Act**.
6. The amount that **you** receive as retirement payments or the amount **your** spouse and **your** children receive as retirement payments because **you** are receiving retirement payments under:
 - a. the United States Social Security **Act**;
 - b. the Canada Pension **Plan**;
 - c. the Quebec Pension **Plan**; or
 - d. any similar **Plan** or **Act**.
7. The amount **you** earn or receive from any form of employment.
8. The amount **you** receive from any unemployment compensation **law**.
9. The amount that **you** receive, or are eligible to receive, under:
 - a. a workers' compensation **law**;
 - b. an occupational disease **law**; or
 - c. any other **act** or **law** with similar intent.

With the exception of retirement payments, **we** will only subtract **deductible sources of income** which are payable as a result of the same disability.

We will not reduce **your** payment by **your** Social Security retirement income if **your** disability begins after age 65 and **you** were already receiving Social Security retirement payments.

IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income **you** earn from any form of employment, once **we** have subtracted any **deductible source of income** from **your gross monthly payment**, **we** will not further reduce **your** payment due to a cost of living increase from that source.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

When **we** determine that **you** may qualify for benefits for which **you** are eligible in the **deductible sources of income** section, **we** will estimate **your** entitlement to these benefits. **We** can reduce **your** benefit under the policy by the estimated amounts if such benefits:

1. have not been awarded or denied; or
2. have been denied and the denial is being appealed.

Your gross monthly payment will NOT be reduced by the estimated amount if **you**:

1. apply for the disability payments for which **you** are eligible in the **deductible sources of income** section and pursue them with reasonable diligence, including any administrative levels of appeal that are available through the appropriate governing boards; and
2. sign **our** form. This form states that **you** promise to pay **us** any overpayment caused by an award and **we** shall be entitled to impose a constructive trust on any such award.

If **your gross monthly payment** has been reduced by an estimated amount, **your gross monthly payment** will be adjusted when **we** receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals **we** determine are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to **you**.

If **you** receive a lump sum payment from any **deductible source of income**, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime as determined by **us**.

NON-DEDUCTIBLE SOURCES OF INCOME

We will not subtract from **your gross monthly payment** income **you** receive from, the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax-sheltered annuities;
5. stock ownership plans;
6. credit disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension plans;
10. franchise disability income plans;
11. individual disability plans paid for by the **insured person**;
12. a retirement plan from another employer;
13. individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is the greater of:

1. \$100; or
2. 15% of **your gross monthly payment**.

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment**. **Your maximum period of payment** is stated in the BENEFITS AT A GLANCE, will be paid during a continuous period of disability, and will be based on **your** age at disability.

WHEN PAYMENTS END

We will stop sending **you** payments and **your** claim will end on the earliest of the following:

1. the end of the **maximum period of payment**;
2. the date **you** are no longer disabled under the terms of the policy;
3. the date **you** fail to submit proof of continuing disability;
4. the date **you** die;
5. the date **you** are no longer under the **appropriate care** of a **doctor**;
6. [during the **regular occupation period**] when **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not;[
7. after the **regular occupation period**, when **you** are able to work in any **gainful occupation** on a **part-time basis** but **you** do not; or]
8. the date **your disability earnings** exceed 80% of **your indexed monthly earnings**; or
9. after 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay a benefit for any period of disability during which **you** are incarcerated.

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities caused by, contributed to by, or resulting from **your**:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor**;
6. participation in a war, declared or undeclared, or any act of war;
7. active military duty;
8. active participation in a riot;
9. engaging in any illegal or fraudulent occupation, work, or employment;
10. commission of a crime for which **you** have been convicted;
11. elective surgery except when required for **your appropriate care** as a result of **your injury or sickness**; or
12. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING CONDITION LIMITATION

[Benefits will not be paid if **your** disability begins in the first 12 months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which **you** received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to **your** effective date of coverage.

[Benefits will not be paid if **your** disability begins in the first [12-24] months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1. **you** received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the [3-12] months just prior to **your** effective date of coverage; and
2. **you** were not **treatment free** for [6-12] consecutive months after **your** effective date of coverage].

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The lifetime cumulative **maximum period of payment** for all disabilities due to **mental illness**, alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital, health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement.
If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days.
If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.
2. In addition to Item 1, if **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment**, whichever occurs first.

We will not apply the **mental illness** limitation to a disability due to dementia if it is a result of:

1. stroke;
2. trauma;
3. viral infection; or
4. Alzheimer's disease.

RECURRENT DISABILITY

If **you** have a **recurrent disability**, and after **your** prior disability ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as **your** prior claim.

Your disability will be treated as a new claim if **your** current disability:

1. is unrelated to **your** prior disability; or
2. after **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new elimination period.

If **your Employer's** plan of coverage under the policy terminates and **you** become eligible for payments under any other group disability plan that replaces **your Employer's** plan of coverage under **our** policy, **you** will not be eligible for payments under **our** policy.

BENEFITS IF YOU DIE - SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your last monthly payment** if, on the date of **your** death:

1. **your** disability had continued for 180 or more consecutive days; and
2. **you** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors**, payment will be made to **your** estate, unless there is none. In this case, no payment will be made.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.

IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)

If **you** are not in **active employment** due to **injury, sickness** or a **leave of absence** on the date **your Employer** changes insurance carriers to **our** policy, and **you** were covered under the prior policy at the time **your Employer's** coverage under **our** policy became effective, **we** will provide continuity of coverage under **our** policy. In order for this provision to apply, the prior policy's coverage must be similar to **your Employer's** plan of coverage under **our** policy.

If **you** are not in **active employment** due to **injury, sickness, or leave of absence** on the effective date of **your Employer's** plan of coverage under **our** policy, and **you** would otherwise be eligible to become insured under **our** policy, **we** will provide limited coverage under **our** policy. Coverage under this provision will begin on the effective date of **your Employer's** plan of coverage under **our** policy and will continue until the earliest of:

1. the end of the month following the date **you** return to **active employment**; or
2. the end of any period of continuance or extension provided under the prior policy; or
3. the date coverage would otherwise end, according to the provisions of **our** policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under **our** policy will apply.]

IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)

We may send a payment if **your** disability is caused by, contributed by or results from a **pre-existing condition** if:

1. **you** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy; and
2. **you** have been continuously covered under **our** policy from the effective date of **your Employer's** plan of coverage under **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our** policy; or
2. the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of **our** policy, but **you** do satisfy the prior policy's **pre-existing condition** provision:

1. **your monthly payment** will be the lesser of:
 - a. the **monthly payment** that would have been payable under the terms of the prior policy if it had remained in force; or
 - b. the **monthly payment** under **our** policy; and
2. benefits will end on the earlier of:
 - a. the date benefits end under **our** policy, as described under the WHEN PAYMENTS END provision; or
 - b. the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either **our** policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our** policy will apply.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these services, at **our** sole discretion. In order to be eligible for vocational rehabilitation services, **you** must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help **you** return to gainful employment. As **your** file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of **your** eligibility for these services.

If **we** determine that vocational rehabilitation services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you**.

The **vocational rehabilitation plan** may include at **our** sole discretion, but is not limited to, the following services:

1. coordination with **your Employer** to assist **you** to return to work;
2. evaluation of adaptive equipment or job accommodations to allow **you** to work;
3. evaluation of possible workplace modifications which might allow **you** to return to work in **your regular occupation** or another job or occupation;
4. vocational evaluation to determine how **your** disability may impact **your** employment options;
5. job placement services, including resume preparation services and training in job-seeking skills;
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance **your** ability to work.

WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment from **us**, an additional Workplace Modification Benefit may be payable to **your Employer** for **your** benefit. **We** may reimburse **your Employer** for up to 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** may pay will not exceed the lesser of:

1. two times **your** last **monthly payment**; or
2. \$2,000.

To qualify for this reimbursement, **you** must:

1. be disabled according to the terms of the policy; and
2. have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include:

1. input from the **Employer**, **you** and **your doctor**;
2. the purpose of the proposed workplace modification;
3. the expected completion date of the workplace modification; and
4. the cost of the workplace modification.

We will reimburse the costs of the workplace modification when **we**:

1. approve the proposal in writing;
2. receive proof from **your Employer** that the workplace modification is complete; and
3. receive proof of the costs incurred by **your Employer** for the workplace modification.

This benefit is available on a one time basis.

LONG TERM DISABILITY CLAIM INFORMATION

NOTICE OF CLAIM

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to **us** within 30 days after the date **your** disability begins. The notice may be given to **us** at **our** home office or to **our** authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such notice within that time, and the notice was given as soon as reasonably possible.

The claim form is available from **your Employer**, or **you** can request a claim form from **us**. If **you** do not receive the form from **us** within 15 days of **your** request, send **us** written proof of claim without waiting for the form. **We** will consider **you** to have met the requirements of the policy as it relates to proof of loss if **we** receive proof within the timeframe described in the PROOF OF YOUR CLAIM provision.

You must notify **us** immediately when **you** return to work in any capacity.

FILING A CLAIM

You and **your Employer** must fill out **your** own sections of the claim form and then give it to **your** attending **doctor**. **Your doctor** should fill out his or her section of the form and send it directly to **us**.

PROOF OF YOUR CLAIM

You must send **us** written proof of **your** claim no later than 90 days after **your** elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at **your** expense, must show:

1. that **you** are under the **appropriate care** of a **doctor**;
2. the date **your** disability began;
3. the cause of **your** disability;
4. the appropriate documentation of **your** earnings and **your** activities;
5. the extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation**;
6. the name and address of any **hospital, health facility** or **institution** where **you** received treatment, including all attending **doctors**; and
7. documentation of prior disability coverage, if applicable.

In some cases, **you** will be required to give **us** authorization to obtain additional medical information, and to provide non-medical information as part of **your** proof of claim, or proof of continuing disability. **We** will deny **your** claim, or stop sending **you** payments, if the appropriate information is not submitted within 45 days of the request.

You or **your Employer** must notify **us** immediately when **you** return to work in any capacity.

MAKING PAYMENTS

Once **your** claim has been approved, **we** will send **you** a payment at the end of each month for any period for which **we** are liable.

OVERPAID CLAIMS

We have the right to recover any overpayments due to:

1. fraud;
2. any administrative error **we** make in processing a claim; or
3. **your** receipt of **deductible sources of income**.

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made.

We will not recover more money than the amount **we** paid **you**. However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

SERFF Tracking Number: CMTR-126727617 State: Arkansas
 Filing Company: Commercial Travelers Mutual Insurance State Tracking Number: 46258
 Company
 Company Tracking Number: LTD2009CERT(MET)
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
 Product Name: LTD-MET
 Project Name/Number: LTD-MET/LTD2009POL(MET)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Disapproved	12/30/2010
Comments: Readability		
Attachment: Flesch.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Disapproved	12/30/2010
Comments: 50976 Employer Application 80611 Employee Application 50802 Application/Request for Enrollment in group trust 80008 Application/Group Enrollment		
Attachments: 50976 (3-10).pdf 80611(MO).pdf 50802.pdf 80008.pdf		

	Item Status:	Status Date:
Satisfied - Item: Trust Agreement	Disapproved	12/30/2010
Comments: Trust Agreement		
Attachment: Trust Agreement.pdf		

	Item Status:	Status Date:

SERFF Tracking Number: CMTR-126727617 State: Arkansas
Filing Company: Commercial Travelers Mutual Insurance State Tracking Number: 46258
Company
Company Tracking Number: LTD2009CERT(MET)
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: LTD-MET
Project Name/Number: LTD-MET/LTD2009POL(MET)
Satisfied - Item: Commerce Bank letter Disapproved 12/30/2010
Comments:
Commerce Bank Letter
Attachment:
Commerce Trust Ltr - 12-9-2005.pdf

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

This is to CERTIFY that the forms listed on the attached page(s) are in compliance with Insurance Policy Readability Laws.

A. Option Selected

1. The forms are scored for Flesch reading ease test as one unit and the combined score is _____.
2. The forms are scored separately for the Flesch reading ease test. Scores for each form are indicated on the attached page(s).

B. Test Option Selected

1. Test was applied to entire form.
2. Test was applied on sample basis. Form contains more than 10,000 words. Copy of form enclosed indicating word samples tested.

C. Standards of Certification

A checked block indicates the standard has been achieved.

1. The text of the form achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A. above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specifications pages, schedules and tables.)
3. The layout and spacing of the forms separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face or otherwise stand out, significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used.
6. The style, arrangement and overall appearance of the forms give no undue prominence to any portion thereof or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included. (This applies only if the form has more than 3,000 words or consists of more than 3 pages)



Donna J. Guminiak, FLMI, ACS, ALHC, AIRC, CCP, AIS
Compliance Officer

Date: March 11, 2010

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY

Flesch Scores for form(s) submitted with this filing are:

FORM #	SENTENCES	WORDS	SYLLABLES	FLESCH
LTD2009POL(MET)(MO)	68	986	1539	60
LTD2009CERT(MET)(MO)	666	8447	13658	57



MULTIPLE EMPLOYER TRUST INSURANCE POLICY APPLICATION

Trustee Name: ABC Trust

Street Address: 123 Any Street

City: Any City State: ST Zip Code: 12345

Coverage Applied For:

- Group Long Term Disability Income Insurance
 Group Short Term Disability Income Insurance
 Group Intermediate Disability Income Insurance

I understand and agree that if this application is accepted by the Company, coverage will begin on the date of acceptance.

Signed at Any City, ST
City, State

on this 1st day of March, 2010

Trustee, by Jack Doe
Signature

Name Jack Doe
Please Print Name

Title or Position Vice President

Witness Jane Smith

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
Commercial Travelers Building
70 Genesee Street · Utica, New York 13502

Employee Application for Group Insurance Evidence of Insurability

Check the company(s) you are applying to:

Disability Income Underwritten by:

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502

Term Life Underwritten by:

FIDELITY SECURITY LIFE INSURANCE COMPANY
POLICYHOLDER SERVICE • 70 GENESEE STREET • UTICA, NEW YORK 13502

A1. EMPLOYEE INFORMATION (Complete for ALL Enrollments)

EMPLOYEE NAME (Last, Middle Initial, First)			BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYER	LOCATION
DOH (Full-Time)	HRS/WK	EARNINGS	JOB TITLE	SS#	HEIGHT	WEIGHT

A2. APPLICANT (Spouse and Dependent Enrollment Information)

APPLICANT NAME (Last, Middle Initial, First)	BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO EMPLOYEE	HEIGHT	WEIGHT
--	------------	--	--------------------------	--------	--------

B. COVERAGE SELECTION (Complete for ALL Enrollments) Your Group plan may not include all coverages listed below.

Basic Coverage (to be completed by Employer)		Indicate coverage and amount selected			
Class	Amount	Optional Coverages		Amount	
Life		Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
AD&D		Dependent Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
STD		STD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
LTD		LTD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other		Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

C. WAIVER OF INSURANCE (Complete only if you are required to pay any portion of the premium and decide not to participate.)

Coverage(s) Declined <input type="checkbox"/> All Coverage(s) <input type="checkbox"/> Specific Coverage(s)	Name of Coverage(s) Declined
---	------------------------------

D. BENEFICIARY DESIGNATION (Complete ONLY for Life or AD&D Enrollments)

FULL NAME	RELATIONSHIP	DATE OF BIRTH	BENEFIT %	SS# (Optional)
Primary			%	
Primary (Optional)			%	
Contingent (Optional)			%	

E. INSURABILITY QUESTIONNAIRE - (Complete Section E if amounts applied for require proof of good health.)

Circle condition & record details of Yes answers below.

	Emp.		Spouse /Dep.	
1. Within the past 5 years, have you been counseled, treated or told by a physician or member of the medical profession that you had; high blood pressure, diabetes, cancer or had any disease or disorder of the heart, kidney, liver, intestines, stomach, spine, bones, respiratory system or the mental/nervous system?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Within the past 5 years have you been diagnosed by or received treatment from a physician or member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Within the past 5 years have you consulted or been attended by any physician, member of the medical profession or counselor for any health reason or condition not disclosed in the preceding questions, including substance abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Are you presently receiving any treatment by a physician or member of the medical profession or taking any medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been rated or limited in any way for life, health or disability insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Question Number & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name, Complete Address and Telephone No. of Attending Physician or Other Practitioner

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

I hereby declare and agree that the answers given on this form are true and accurate to the best of my knowledge and belief. I understand that the insurance applied for shall take effect only upon approval of this application by the Insurance Company. I have read or had read to me the completed application and I realize that any false statement or misrepresentation may result in loss of coverage under the policy. I hereby authorize and direct my Employer to deduct from my earnings amounts sufficient to cover my contributions toward the cost of my participation in the Group Plan.

I authorize any medical professional, medical care institution or insurer, having information available as to insurance coverage, medical care, advice or treatment with respect to any physical or mental condition regarding me, to give the information to the insurance company(ies) named on this application. NOTE: This authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The applicant/insured IS NOT authorizing the Company to forward the results of any new test requested by the company to any outside non-affiliated Company or entity not under specific contract to perform underwriting service. I understand that this information will be used by the company(ies) providing coverage to determine insurability. I agree this authorization is valid for two years from the date signed. I know that I have the right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. I know that I may revoke this authorization at any time, subject to the rights of the Company who acted in reliance on the authorization prior to the notice of my revocation, by sending such notice to the above address.

Date _____ City _____ State _____

Employee's Signature _____ Spouse's Signature _____

CTGROUP USE ONLY	POLICY NUMBER	EFFECTIVE DATE
------------------	---------------	----------------

Request For Participation In The Multiple Employer Group Insurance Trust

Check the company(s) you are applying to:

- COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502
 MONITOR LIFE INSURANCE COMPANY OF NEW YORK • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502
 FIDELITY SECURITY LIFE INSURANCE COMPANY • POLICYHOLDER SERVICE • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502

A. EMPLOYER INFORMATION

FIRM NAME _____ ADDRESS _____ NATURE OF BUSINESS/ TELEPHONE _____ SIC CODE _____ NUMBER (____) _____ EMPLOYER _____ CONTACT (Please Print) _____ TITLE _____	DATE FIRM ESTABLISHED _____ TYPE OF BUSINESS <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____
---	---

B. EMPLOYEE INFORMATION, ELIGIBILITY AND EFFECTIVE DATE

Eligible Employees are: All active full-time employees who devote a minimum of 30 hours per week to the service of the above named employer at their regular and customary place of business.	
Requested Changes to the Definition of Eligibility <input type="checkbox"/> None <input type="checkbox"/> Details _____	Effective Date ____ / ____ / ____
Are all Eligible Employees participating in: Workers' Comp <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No If no to either question, provide details: _____	Employees on Payroll Total _____
Are all employees currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete form on the reverse side.	Eligible _____
When are employees eligible for coverage? New Employees: <input type="checkbox"/> One Month <input type="checkbox"/> Two Months <input type="checkbox"/> Three Months <input type="checkbox"/> Other _____ Current Employees: <input type="checkbox"/> Effective Immediately <input type="checkbox"/> Same as New Employees	Part-Time _____

C. PLANS SELECTED

	% Paid by Employer																											
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Basic Life/AD&D</td> <td style="width: 25%;">Flat Benefit <input type="checkbox"/></td> <td style="width: 25%;">Class Schedule <input type="checkbox"/></td> <td style="width: 25%;">Multiple of Earnings <input type="checkbox"/></td> </tr> <tr> <td>\$10,000 Minimum* \$75,000 Maximum</td> <td>Benefit Amount _____</td> <td>Plan 1 <input type="checkbox"/> \$50,000/\$25,000</td> <td>1 Times <input type="checkbox"/> 2 Times <input type="checkbox"/> Max Benefit _____</td> </tr> </table>	Basic Life/AD&D	Flat Benefit <input type="checkbox"/>	Class Schedule <input type="checkbox"/>	Multiple of Earnings <input type="checkbox"/>	\$10,000 Minimum* \$75,000 Maximum	Benefit Amount _____	Plan 1 <input type="checkbox"/> \$50,000/\$25,000	1 Times <input type="checkbox"/> 2 Times <input type="checkbox"/> Max Benefit _____	_____ %																			
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*Subject to age reductions. **Minimum of three participants. ***Employer may purchase either IDI or LTD.

D. EXISTING COVERAGE—Current coverage should not be cancelled until you receive written Home Office approval.

Does the employer currently have coverage similar to the coverage applied for? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", provide details, or provide a copy of a booklet/certificate.		
TYPE OF COVERAGE	SUMMARY OF BENEFITS	INSURANCE COMPANY

E. PREMIUM REQUIREMENTS

Deposit to be applied toward payment of premiums for coverage requested (minimum of one month's premium): \$ _____ Premium Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other _____
--

F. EMPLOYEES NOT CURRENTLY ACTIVE AT WORK: None See Below

NAME	DOB	SEX	DATE LAST WORKED	DATE EXPECTED BACK	REASON FOR ABSENCE

G. PARTICIPATION AGREEMENT FOR THE MULTIPLE EMPLOYER GROUP INSURANCE TRUST COMPLETED REQUEST FOR COVERAGE ON REVERSE SIDE

The undersigned employer hereby elects to participate in the Multiple Group Insurance Trust, a Missouri Trust, and agrees to be bound by its terms and provisions which, subject to governance of the laws of the state of Missouri, may be amended from time to time. It is agreed that participation under any plan of insurance issued by such Trust will not become effective until the Employer is accepted by the insurance carrier issuing the coverage and notice of approval has been transmitted to the Employer.

The plan of insurance is subject, in every respect, to the group policy which alone constitutes the AGREEMENT under which benefits will be paid.

It is understood that the Employer intends to establish an employee benefit plan through this Trust participation and neither the Administrator, the Trustee nor the insurance carrier will act as "sponsor" or "fiduciary" of any such plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA).

Employer Representation

I hereby certify that all statements are complete and true to the best of my knowledge

X

SIGNED (Employer)	TITLE
SIGNED AT (City & State)	DATE SIGNED

H. AGENT DATA

The agent named below is hereby recognized as the Agent of Record to receive credit for this submission according to company rules and regulations on coverage issued in accordance with this request for benefits, provided he or she is duly licensed as required by law.

I hereby certify that to the best of my knowledge and belief, all of the foregoing statements and answers are true.

SIGNED (Agent) X _____	DATE SIGNED _____
FULL NAME (Please Print) _____	SOCIAL SECURITY NUMBER _____
NAME OF AGENCY/ INSURANCE COMPANY _____	BUSINESS PHONE () _____
ADDRESS _____	Are you currently appointed with us? <input type="checkbox"/> Yes <input type="checkbox"/> No

Indicate to whom commission should be paid and any commissions splits if applicable _____ % of Split

Group Enrollment Instructions

- New Employees** - Use this form if employee qualifies for Guaranteed Issue Benefits. Otherwise complete the employee Application for Group Insurance.
- Changes/Reinstatements** - To record a change on a currently insured employee, or request reinstatement of coverage, mark the appropriate box below and complete both sides of the card including signature and date.

Policy Number	<input type="checkbox"/> New Employee	<input type="checkbox"/> Change	Billing Loc.#	Class
	<input type="checkbox"/> Reinstatement			
Name of Employer			Employee's Occupation	
Certificate No.	Name of Employee (Please Print)		Date of Birth	
Dependent Life	Sex	Marital Status	Salary	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> M <input type="checkbox"/> F		\$	Per
Date of Full Time Employment	How many hours are you working per week in the			
Mo. Day Yr.	above employer's business?			
Beneficiary (For Life and AD&D Only) (First, Middle, Last)			Relationship of Beneficiary	
I Authorize and direct my employer to deduct an amount sufficient to cover my contribution toward the cost of participation in the group insurance plan from my earnings. <input type="checkbox"/> Yes				
To the best of my knowledge, all of the above information is correct. <input type="checkbox"/> No				
Signature		Social Security Number		Date Signed
X				

80008

**Commercial Travelers Mutual Insurance Company and
Fidelity Security Life Insurance Company**

T R U S T A G R E E M E N T

THIS TRUST AGREEMENT, entered into as of this 26th day of April, 1993 (hereinafter called the "Agreement Date", by and between ROBERT N. SHELDON and DWIGHT E. VICKS, JR., Utica, New York (hereinafter called "TRUSTORS") and UNITED MISSOURI BANK, PO Box 419692, Kansas City, Missouri (hereinafter referred to as "TRUSTEE").

WHEREAS, TRUSTORS desire to create a trust on behalf of certain employers ("PARTICIPATING MEMBERS") for the purpose of establishing plans of group insurance for the benefit of those members and their employees and dependents who wish to participate.

WHEREAS, the designated TRUSTEE is willing to undertake said TRUST under the terms of this AGREEMENT;

NOW THEREFORE, in consideration of the foregoing, and of the agreements hereinafter provided, it is agreed as follows:

NAME

This TRUST shall be known as the MULTIPLE EMPLOYER GROUP INSURANCE TRUST.

DEFINITIONS

1. PLAN OF GROUP INSURANCE -- Any contract of group insurance issued pursuant to this AGREEMENT, including any rider, endorsement or amendment made a part thereof; and the eligibility requirements and any other terms or conditions therefore, as may be determined by the INSURER(s).

2. TRUSTEE -- UNITED MISSOURI BANK, Kansas City, Missouri, a national Banking association organized under the law of the United States and established in the city of Kansas City, Missouri (which, with any successor or successors thereto is hereinafter referred to as the "TRUSTEE").

3. TRUSTORS - ROBERT N. SHELDON and DWIGHT E. VICKS, JR.
4. ADMINISTRATOR -- COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY, 70 Genesee Street, Utica, NY.
5. INSURER -- COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY, MONITOR LIFE INSURANCE COMPANY OF NEW YORK or any other insurance company authorized to do business in the state of Missouri, which will issue a policy or policies of insurance under this TRUST.
6. PARTICIPATING MEMBER -- Any employer who agrees, in writing, to participate in the TRUST.
7. TRUST -- The original TRUST as established by this AGREEMENT and all modifications and amendments thereto.

WITNESSETH

The TRUSTORS are interested in arranging for group insurance programs for employee groups who become eligible to participate in such program. It is the purpose of the TRUSTORS, to that end, to create this TRUST.

The TRUSTEE will be custodian, owner and holder of all insurance contracts.

The TRUSTEE has agreed to accept such TRUST arrangement and to act as custodian, owner and holder of the insurance contracts subject to the conditions and limitations hereinafter set forth; and the ADMINISTRATOR and INSURER(s) have agreed to assume the responsibility of all administrative duties in connection with the insurance programs for the TRUSTOR and TRUSTEE, subject to the conditions and limitations hereinafter contained.

NOW, THEREFORE, in consideration of the promises and mutual covenants and conditions hereinafter contained, the parties agree as follows:

1. The ADMINISTRATOR shall, from time to time, on behalf of the TRUSTEE (as Policyowner) apply for an insurance contract or contracts providing group insurance for the PARTICIPATING MEMBERS, in such amounts and subject to such conditions as the ADMINISTRATOR shall determine.
2. The INSURER(s) shall receive applications for insurance coverage under the group insurance contracts, collect premiums, make payments as required and perform any and all functions as may be necessary for the administration of the insurance programs.
3. The TRUSTORS shall not assume any responsibilities nor be liable for any duties or responsibilities with respect to the TRUST, including but not limited to all insurance matters, claim payments or handling of funds. The TRUSTORS shall have no involvement beyond the creation of this TRUST and the TRUSTOR's interest will cease immediately upon the first employer becoming a PARTICIPATING MEMBER under this TRUST.
4. The TRUSTEE shall not assume any responsibility nor be liable for collection, remittance, forwarding or payment of premium for the TRUST or its PARTICIPATING MEMBERS or for the continuation

of the coverage, or to apply for or obtain renewals thereof, or to replace same in the event of cancellation or termination thereof, nor shall it have any duties or responsibilities with respect to the payment, settlement, processing or presentment of claims.

5. All correspondence and monies that the TRUSTEE may receive shall be promptly turned over to the ADMINISTRATOR at its home office.
6. All premiums shall be paid directly to the INSURER(s), and the TRUSTEE shall not have any responsibilities hereunder, except that the TRUSTEE shall act as holder of the group insurance contracts, and shall act as policyowner for all such group insurance contracts.
7. The TRUSTORS are not required or authorized to incur any expense or obligation on behalf of the PARTICIPATING MEMBERS or the TRUSTEE in connection with the administration of the insurance programs. All expenses for service and material incurred in connection with the administration of said insurance programs are to be borne exclusively by the INSURER(s).
8. There shall be no obligation, direct or implied, upon any PARTICIPATING MEMBER of this TRUST arising out of this AGREEMENT, except for the payment of premium for insurance.
9. This TRUST AGREEMENT shall terminate one hundred (100) days after the termination date of the last insurance policy held by the TRUST.
10. In consideration of the services rendered by the TRUSTEE, the ADMINISTRATOR agrees to pay said TRUSTEE a reasonable annual fee for each year that this TRUST is in force, and to reimburse the TRUSTEE for all its expense, including court costs and

reasonable attorney's fees in the event that the TRUSTEE is a party to litigation, or in the event the TRUSTEE reasonably feels it should consult legal counsel in connection with its powers or duties under this TRUST.

11. All contract rights of the PARTICIPATING MEMBERS shall be identified by the ADMINISTRATOR, for the TRUSTEE, under this TRUST in sub-trusts determined by the Federal Office of Management and Budget's Standard Industrial Classification Code of the principal business activity of the PARTICIPATING MEMBER as follows:

Sub-Trust A -- All assets and contract rights held by the TRUSTEE under a contract construction industry classification.

Sub-Trust B -- All assets and contract rights held by the TRUSTEE under a manufacturing organic material industry classification.

Sub-Trust C -- All assets and contract rights held by the TRUSTEE under a manufacturing equipment, machinery and metal industry classification.

Sub-Trust D -- All assets and contract rights held by the TRUSTEE under a transportation, communication and other public utilities industry classification.

Sub-Trust E -- All assets and contract rights held by the TRUSTEE under a wholesale trade industry classification.

Sub-Trust F -- All assets and contract rights held by the TRUSTEE under a retail trade industry classification.

Sub-Trust G -- All assets and contract rights held by the TRUSTEE under a finance, insurance, real estate industry classification.

Sub-Trust H -- All assets and contract rights held by the TRUSTEE under a personal and business services industry classification.

Sub-Trust I -- All assets and contract rights held by the TRUSTEE under a health, legal and professional services industry classification.

Each of the sub-trusts shall be deemed to have been established by the first two employers within the given industry to become PARTICIPATING MEMBERS. This TRUST AGREEMENT shall also serve as the TRUST AGREEMENT for each of the sub-trusts.

The TRUSTEE shall create and maintain such Sub-Trusts as listed above and hold assets and contract rights in such Sub-Trusts only upon the written direction of the ADMINISTRATOR.

12. The ADMINISTRATOR and INSURER(s) hereby agrees to prepare and file any and all tax or information returns, Federal, State or local, that may now or hereafter be required and further agrees to prepare and file all documents or forms that may now or hereafter be required by law.
13. In the event the TRUSTEE resigns, becomes incapacitated or is otherwise unable or unwilling to act as TRUSTEE, the ADMINISTRATOR, as agent of the PARTICIPATING MEMBERS of said TRUST, shall appoint a SUCCESSOR TRUSTEE.

14. The TRUSTEE or any successor in trust may resign by mailing in registered form, written notice thereof to the ADMINISTRATOR not less than thirty (30) days prior to the effective date of such resignation. Upon receipt of such a notice, the ADMINISTRATOR may appoint a successor immediately.
15. In the event that the ADMINISTRATOR, as agent of the PARTICIPATING MEMBERS of said Trust, determines that Administration of said Trust would be better served by appointing a successor trustee, ADMINISTRATOR shall appoint a SUCCESSOR TRUSTEE upon not less than thirty (30) days notice to the existing TRUSTEE.
16. Each SUCCESSOR TRUSTEE appointed hereunder shall have the same rights, immunities, and duties conferred or imposed herein upon the TRUSTEE, provided however, that a successor or successor in trust shall not be liable for acts or neglects of any predecessor trustee.
17. The ADMINISTRATOR hereby agrees to defend and hold the TRUSTEE harmless of and from any and all claims or demands made or brought against the TRUSTEE by any person, firm, corporation, or group arising out of its undertaking to act as TRUSTEE hereunder, and from and against any losses the TRUSTEE may incur or sustain in connection with this TRUST occasioned by any act, neglect or misconduct by the ADMINISTRATOR, and to save the TRUSTEE free of and from any liability whatsoever.
18. The INSURER(s) hereby agrees to defend and hold the ADMINISTRATOR harmless of and from any and all claims or demands made or brought against the ADMINISTRATOR by any person, firm, corporation, or group in connection with a PLAN OF GROUP INSURANCE occasioned by any act, neglect or misconduct by the INSURER(s), and to save the ADMINISTRATOR free of and from any liability whatsoever.

19. This TRUST AGREEMENT may be modified by the written mutual consent of the TRUSTEE, ADMINISTRATOR and INSURER(s) then having in-force policies issued to the TRUSTEE.

20. This TRUST AGREEMENT is executed under the laws of the state of MISSOURI and the laws of that state shall control in determining the validity, meaning, effect and enforcement hereof.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals the day and year first above written.

ATTEST:

Shirley A. Mondrick Asst Sec.

ATTEST:

Shirley A. Mondrick

ATTEST:

David R. Milner

UNITED MISSOURI BANK, TRUSTEE

By William A. Horn
Title: Trustee

By Donald E. Vacker
Trustor

By Robert M. Sheldon
Trustor

IN WITNESS WHEREOF, the ADMINISTRATOR hereby accepts and agrees to the terms set forth herein.

ATTEST:

Shirley A. Mondrick

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY

By Hubert E. Truvett
Title: President

IN WITNESS WHEREOF, the INSURER(s) hereby accepts and agrees to the terms set forth herein.

ATTEST:

Shirley A. Mondrick

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY

By Hubert E. Truvett
Title: President

ATTEST:

Shirley A. Mondrick

MONITOR LIFE INSURANCE
COMPANY OF NEW YORK

By Donald E. Truvett
Title: President

ROOM ACCOUNT FILES 8
CABINET STANDARD FILES
FOLDER One Document
DOC DATE 12-9-05
NAME KEY MKL EMP
FROM Taylor
SUBJECT Accept as Successor TTE
TRUST# 750144016
LINKS _____

December 9, 2005

David R. Milner
General Counsel/Secretary
Commercial Travelers Mutual Insurance Company
Commercial Travelers Building
70 Genesee Street
Utica, NY 13502

RE: Multiple Employer Group Insurance Trust 75-0144-01-6

Dear Mr. Milner:

Please accept this letter as documentation that The Commerce Trust Company accepts its appointment as Successor Trustee of the above referenced plan.

The Trust Agreement in my file is dated April 26, 1993 and references United Missouri Bank as Trustee. I am assuming that as soon as you have our acceptance of duties as Successor Trustee that the Trust Agreement will be amended and/or revised.

Please forward an original Trust Agreement to my attention so that The Commerce Trust Company may execute.

I am enclosing my business card for your files. If you have any questions, please do not hesitate to contact me at 816-234-2716.

Sincerely,

Phyllis I. Taylor
Assistant Vice President
Institutional Trust Services
The Commerce Trust Company

cc: Bryan Smith, The Commerce Trust Company

Enclosures



November 11, 2003

The Commerce Trust Company
922 Walnut Street TBMZ-1
Kansas City, MO 64106

Attention: Bryan J. Smith

Dear Bryan:

I have enclosed a copy of the Trust Agreement regarding our Multiple Employer Trust (MET) in Missouri.

There are presently five (5) insurance policies held by UMB as current Trustee. I have attached a document from UMB showing these five policies.

We are hopeful that you will determine that there is actually only one (1) trust with the fee of \$3,000.00. Paragraph 11 of the agreement refers to sub-trusts but they are only for our industry classifications to determine rates, etc.

The only "assets" held by the Trustee are those policies referred to and I do not believe the assets are allocated further to sub-trusts.

Please let me know of your requirements as soon as possible. We are hopeful of finding a successor Trustee by the end of the month.

Very truly yours,

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY

A handwritten signature in cursive script that reads "David R. Milner".

David R. Milner
General Counsel/Secretary

DRM/mcp
Encs.

ROOM ACCOUNT FILES
CABINET STANDARD FILES
FOLDER DOCS
DOC DATE 11-23-03
NAME KEY MUL EMP
FROM David Milner
SUBJECT Trust Agreement
TRUST# 75-0144-01-6
LINKS

T R U S T A G R E E M E N T

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WHEREAS, the designated TRUSTEE is willing to undertake said TRUST under the terms of this AGREEMENT;

NOW THEREFORE, in consideration of the foregoing, and of the agreements hereinafter provided, it is agreed as follows:

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5. INSURER -- COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY, MONITOR LIFE INSURANCE COMPANY OF NEW YORK or any other insurance company authorized to do business in the state of Missouri, which will issue a policy or policies of insurance under this TRUST.
6. PARTICIPATING MEMBER -- Any employer who agrees, in writing, to participate in the TRUST.
7. TRUST -- The original TRUST as established by this AGREEMENT and all modifications and amendments thereto.

WITNESSETH

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The TRUSTEE has agreed to accept such TRUST arrangement and to act as custodian, owner and holder of the insurance contracts subject to the conditions and limitations hereinafter set forth; and the ADMINISTRATOR and INSURER(s) have agreed to assume the responsibility of all administrative duties in connection with the insurance programs for the TRUSTOR and TRUSTEE, subject to the conditions and limitations hereinafter contained.

NOW, THEREFORE, in consideration of the promises and mutual covenants and conditions hereinafter contained, the parties agree as follows:

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6. All premiums shall be paid directly to the INSURER(s), and the TRUSTEE shall not have any responsibilities hereunder, except that the TRUSTEE shall act as holder of the group insurance contracts, and shall act as policyowner for all such group insurance contracts.
7. The TRUSTORS are not required or authorized to incur any expense or obligation on behalf of the PARTICIPATING MEMBERS or the TRUSTEE in connection with the administration of the insurance programs. All expenses for service and material incurred in connection with the administration of said insurance programs are to be borne exclusively by the INSURER(s).
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Sub-Trust B -- All assets and contract rights held by the TRUSTEE under a manufacturing organic material industry classification.

Sub-Trust C -- All assets and contract rights held by the TRUSTEE under a manufacturing equipment, machinery and metal industry classification.

Sub-Trust D -- All assets and contract rights held by the TRUSTEE under a transportation, communication and other public utilities industry classification.

Sub-Trust E -- All assets and contract rights held by the TRUSTEE under a wholesale trade industry classification.

Sub-Trust F -- All assets and contract rights held by the TRUSTEE under a retail trade industry classification.

Sub-Trust G -- All assets and contract rights held by the TRUSTEE under a finance, insurance, real estate industry classification.

Sub-Trust H -- All assets and contract rights held by the TRUSTEE under a personal and business services industry classification.

Sub-Trust I -- All assets and contract rights held by the TRUSTEE under a health, legal and professional services industry classification.

Each of the sub-trusts shall be deemed to have been established by the first two employers within the given industry to become PARTICIPATING MEMBERS. This TRUST AGREEMENT shall also serve as the TRUST AGREEMENT for each of the sub-trusts.

The TRUSTEE shall create and maintain such Sub-Trusts as listed above and hold assets and contract rights in such Sub-Trusts only upon the written direction of the ADMINISTRATOR.

12. The ADMINISTRATOR and INSURER(s) hereby agrees to prepare and file any and all tax or information returns, Federal, State or local, that may now or hereafter be required and further agrees to prepare and file all documents or forms that may now or hereafter be required by law.
13. In the event the TRUSTEE resigns, becomes incapacitated or is otherwise unable or unwilling to act as TRUSTEE, the ADMINISTRATOR, as agent of the PARTICIPATING MEMBERS of said TRUST, shall appoint a SUCCESSOR TRUSTEE.

14. The TRUSTEE or any successor in trust may resign by mailing in registered form, written notice thereof to the ADMINISTRATOR not less than thirty (30) days prior to the effective date of such resignation. Upon receipt of such a notice, the ADMINISTRATOR may appoint a successor immediately.
15. In the event that the ADMINISTRATOR, as agent of the PARTICIPATING MEMBERS of said Trust, determines that Administration of said Trust would be better served by appointing a successor trustee, ADMINISTRATOR shall appoint a SUCCESSOR TRUSTEE upon not less than thirty (30) days notice to the existing TRUSTEE.
16. Each SUCCESSOR TRUSTEE appointed hereunder shall have the same rights, immunities, and duties conferred or imposed herein upon the TRUSTEE, provided however, that a successor or successor in trust shall not be liable for acts or neglects of any predecessor trustee.
17. The ADMINISTRATOR hereby agrees to defend and hold the TRUSTEE harmless of and from any and all claims or demands made or brought against the TRUSTEE by any person, firm, corporation, or group arising out of its undertaking to act as TRUSTEE hereunder, and from and against any losses the TRUSTEE may incur or sustain in connection with this TRUST occasioned by any act, neglect or misconduct by the ADMINISTRATOR, and to save the TRUSTEE free of and from any liability whatsoever.
18. The INSURER(s) hereby agrees to defend and hold the ADMINISTRATOR harmless of and from any and all claims or demands made or brought against the ADMINISTRATOR by any person, firm, corporation, or group in connection with a PLAN OF GROUP INSURANCE occasioned by any act, neglect or misconduct by the INSURER(s), and to save the ADMINISTRATOR free of and from any liability whatsoever.

19. This TRUST AGREEMENT may be modified by the written mutual consent of the TRUSTEE, ADMINISTRATOR and INSURER(s) then having in-force policies issued to the TRUSTEE.

20. This TRUST AGREEMENT is executed under the laws of the state of MISSOURI and the laws of that state shall control in determining the validity, meaning, effect and enforcement hereof.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals the day and year first above written.

ATTEST:
Shirley A. Mendrick
Asst Sec.

UNITED MISSOURI BANK, TRUSTEE
By *William P. Horn*
Title: *Trustee*

ATTEST:
Shirley A. Mendrick

By *Donald E. Visher*
Trustor

ATTEST:
David R. Milne

By *Robert M. Sheldon*
Trustor

IN WITNESS WHEREOF, the ADMINISTRATOR hereby accepts and agrees to the terms set forth herein.

ATTEST:
Shirley A. Mendrick

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY
By *Hubert E. Turvett*
Title: *President*

IN WITNESS WHEREOF, the INSURER(s) hereby accepts and agrees to the terms set forth herein.

ATTEST:
Shirley A. Mendrick

COMMERCIAL TRAVELERS MUTUAL
INSURANCE COMPANY
By *Hubert E. Turvett*
Title: *President*

ATTEST:
Shirley A. Mendrick

MONITOR LIFE INSURANCE
COMPANY OF NEW YORK
By *Donald E. Visher*
Title: *President*

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