

SERFF Tracking Number: JEPT-126576276 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 45382
 Company Tracking Number:
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident
 Project Name/Number: Accident 2010/

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Group Accident

SERFF Tr Num: JEPT-126576276 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-Closed
 State Tr Num: 45382

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewers: Rosalind Minor
 Disposition Date: 04/08/2010

Authors: Cindi Allgire, Matt
 Rotundo, Debbie Turek, Betty
 Spratlen

Date Submitted: 04/08/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Accident 2010

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 04/08/2010

Explanation for Other Group Market Type:

State Status Changed: 04/08/2010

Deemer Date:

Created By: Betty Spratlen

Submitted By: Betty Spratlen

Corresponding Filing Tracking Number:

Filing Description:

Re: Group Accident Forms

Forms: GL41-1-FP AR, et al (See Form Schedule)

The captioned group accident forms are enclosed for your review and approval. These forms are new and will not replace any previously approved forms with your Department. Group Policy Series GL41 and Group Certificate Series GL42 will be marketed by licensed agents and brokers primarily to employer groups, but also may be used with labor union or professional association groups.

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 Product Name: Group Accident
 Project Name/Number: Accident 2010/

The forms provide benefits to insureds for covered accidents, irrespective of expenses incurred. Also enclosed are amendment forms that provide a disability benefit for off-the-job accidents or sicknesses and off-the-job accidents; a Sickness Hospital Confinement benefit; and a Health Assessment Benefit, which will be paid to an insured or covered spouse who has one or more of the listed preventive/wellness tests performed during a period described in the amendment. These amendments are optional, to be included at the request of the group policyholder. Also enclosed are General Amendment forms for this product.

In addition, a new group application is enclosed.

We request that bracketed and underlined material be filed as variable. An Appendix of Variability describing the forms and variables is enclosed.

The required filing documents are also enclosed. Your review and notice of approval will be greatly appreciated.

Company and Contact

Filing Contact Information

Betty Spratlen, Compliance Specialist Elizabeth.Spratlen@lfg.com
 8807 Indian Hills Drive 402-361-2690 [Phone]
 Omaha, NE 68114 402-361-2568 [FAX]

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
 350 Church Street Group Code: 20 Company Type: Group
 Hartford, CT 06103 Group Name: State ID Number:
 (800) 423-2765 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
 Fee Amount: \$2,500.00
 Retaliatory? Yes
 Fee Explanation: 50 forms x's \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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SERFF Tracking Number: JEPT-126576276 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Accident
Project Name/Number: Accident 2010/
The Lincoln National Life Insurance Company \$2,500.00 04/08/2010 35489435

SERFF Tracking Number: JEPT-126576276 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Accident
Project Name/Number: Accident 2010/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/08/2010	04/08/2010

SERFF Tracking Number: *JEPT-126576276* *State:* *Arkansas*
Filing Company: *The Lincoln National Life Insurance Company* *State Tracking Number:* *45382*
Company Tracking Number:
TOI: *H02G Group Health - Accident Only* *Sub-TOI:* *H02G.000 Health - Accident Only*
Product Name: *Group Accident*
Project Name/Number: *Accident 2010/*

Disposition

Disposition Date: 04/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPT-126576276 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 45382
 Company Tracking Number:
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident
 Project Name/Number: Accident 2010/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Form	Face Page	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Provisions Applicable to Participating Organizations	Approved-Closed	Yes
Form	Eligibility and Effective Dates for Personal Accident Insurance	Approved-Closed	Yes
Form	Termination of Personal Accident Insurance	Approved-Closed	Yes
Form	Eligibility for Dependent Accident Insurance	Approved-Closed	Yes
Form	Termination of Dependent Accident Insurance	Approved-Closed	Yes
Form	Premiums and Premium Rates	Approved-Closed	Yes
Form	Policy Termination	Approved-Closed	Yes
Form	Emergency Care Benefits	Approved-Closed	Yes
Form	Treatment Care Benefits	Approved-Closed	Yes
Form	Specific Injuries or Treatments	Approved-Closed	Yes
Form	Transitional Care Benefits	Approved-Closed	Yes
Form	Accidental Death & Dismemberment (AD&D) Benefits	Approved-Closed	Yes
Form	Accidental Dismemberment Benefits	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Beneficiary	Approved-Closed	Yes
Form	Claims Procedures for Accident Insurance	Approved-Closed	Yes
Form	Policy Amendment (Off the Job Accident Disability Benefit)	Approved-Closed	Yes
Form	Policy Amendment (Sickness and Off the Job Accident Disability Benefit)	Approved-Closed	Yes
Form	Policy Amendment (Sickness Hospital	Approved-Closed	Yes

SERFF Tracking Number: JEPT-126576276 State: Arkansas
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 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident
 Project Name/Number: Accident 2010/

	Confinement Benefit)		
Form	Policy Amendment (Health Assessment Benefit)	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form	Face Page	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Eligibility and Effective Dates for Personal Accident Insurance	Approved-Closed	Yes
Form	Termination of Dependent Accident Insurance	Approved-Closed	Yes
Form	Eligibility for Dependent Accident Insurance	Approved-Closed	Yes
Form	Termination of Dependent Accident Insurance	Approved-Closed	Yes
Form	Emergency Care Benefits	Approved-Closed	Yes
Form	Treatment Care Benefits	Approved-Closed	Yes
Form	Specific Injuries or Treatments	Approved-Closed	Yes
Form	Transitional Care Benefits	Approved-Closed	Yes
Form	Accidental Death & Dismemberment (AD&D) Benefits	Approved-Closed	Yes
Form	Accidental Dismemberment Benefits	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Beneficiary	Approved-Closed	Yes
Form	Claims Procedures for Accident Insurance	Approved-Closed	Yes
Form	Certificate Amendment (Off the Job Accident Disability Benefit)	Approved-Closed	Yes
Form	Certificate Amendment (Sickness and Off the Job Accident Disability Benefit)	Approved-Closed	Yes
Form	Certificate Amendment (Sickness Hospital Confinement Benefit)	Approved-Closed	Yes
Form	Certificate Amendment (Health Assessment Benefit)	Approved-Closed	Yes
Form	Certificate Amendment	Approved-Closed	Yes

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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Accident
Project Name/Number: Accident 2010/
Form Application for Group Insurance Approved-Closed Yes

SERFF Tracking Number: JEPT-126576276 State: Arkansas
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 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident
 Project Name/Number: Accident 2010/

Form Schedule

Lead Form Number: GL41-1-FP AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/08/2010	GL41-1-FP AR	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy/Cont Face Page	Initial		51.800	1FPAR.pdf
Approved-Closed 04/08/2010	GL41-2-TC	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy/Cont Table of Contents	Initial		0.000	2TC.pdf
Approved-Closed 04/08/2010	GL41-3-SB	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy/Cont Schedule of Benefits	Initial		51.100	3SB.pdf
Approved-Closed 04/08/2010	GL41-4-DF AR	Policy/Cont ract/Fraternal Certificate:	Policy/Cont Definitions	Initial		50.800	4DFAR.pdf

<i>SERFF Tracking Number:</i>	<i>JEPT-126576276</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45382</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Accident 2010/ Amendmen t, Insert Page, Endorseme nt or Rider</i>		
Approved- Closed 04/08/2010	GL41-5-GP Policy/Cont General Provisions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54.100 5GP.pdf
Approved- Closed 04/08/2010	GL41-5.1- PE Policy/Cont Provisions Applicable ract/Fratern to Participating al Organizations Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	55.100 5_1PE.pdf
Approved- Closed 04/08/2010	GL41-6- ELE Policy/Cont Eligibility and ract/Fratern Effective Dates for al Personal Accident Certificate: Insurance Amendmen t, Insert Page, Endorseme nt or Rider	Initial	52.300 6ELE.pdf
Approved- Closed 04/08/2010	GL41-7-TE Policy/Cont Termination of ract/Fratern Personal Accident al Insurance Certificate: Amendmen t, Insert	Initial	50.300 7TE.pdf

<i>SERFF Tracking Number:</i>	<i>JEPT-126576276</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45382</i>
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<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Accident 2010/</i>		
	<i>Page,</i>		
	<i>Endorseme</i>		
	<i>nt or Rider</i>		
Approved- GL41-8-	Policy/Cont Eligibility for	Initial	57.400
Closed ELD AR	ract/Fratern Dependent Accident		8ELD AR.pdf
04/08/2010	al Insurance		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-9-TD	Policy/Cont Termination of	Initial	64.800
Closed	ract/Fratern Dependent Accident		9TD.pdf
04/08/2010	al Insurance		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-10-	Policy/Cont Premiums and	Initial	59.100
Closed PR	ract/Fratern Premium Rates		10PR.pdf
04/08/2010	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-11-	Policy/Cont Policy Termination	Initial	55.900
Closed PT	ract/Fratern		11PT.pdf
04/08/2010	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		

<i>SERFF Tracking Number:</i>	<i>JEPT-126576276</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Accident 2010/ nt or Rider</i>		
Approved- Closed 04/08/2010	GL41-12- ECB Policy/Cont Emergency Care ract/Fratern Benefits al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	56.000 12ECB.pdf
Approved- Closed 04/08/2010	GL41-13- TCB Policy/Cont Treatment Care ract/Fratern Benefits al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	62.400 13TCB.pdf
Approved- Closed 04/08/2010	GL41-14- SIT Policy/Cont Specific Injuries or ract/Fratern Treatments al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	64.500 14SIT.pdf
Approved- Closed 04/08/2010	GL41-15- TRNCB Policy/Cont Transitional Care ract/Fratern Benefits al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54.100 15TRNCB.pdf
Approved- Closed 04/08/2010	GL41-16- Policy/Cont Accidental Death &	Initial	53.600 16ADD.pdf

SERFF Tracking Number:	JEPT-126576276	State:	Arkansas
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Company Tracking Number:			
TOI:	H02G Group Health - Accident Only	Sub-TOI:	H02G.000 Health - Accident Only
Product Name:	Group Accident		
Project Name/Number:	Accident 2010/		
Closed ADD	ract/Fratern Dismemberment		
04/08/2010	al (AD&D) Benefits		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-16-	Policy/Cont Accidental	Initial	52.600
Closed DSMBR	ract/Fratern Dismemberment		
04/08/2010	al Benefits		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-17-	Policy/Cont Limitations and	Initial	52.100
Closed EX AR	ract/Fratern Exclusions		
04/08/2010	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-18-B	Policy/Cont Beneficiary	Initial	60.100
Closed	ract/Fratern		
04/08/2010	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41-19-	Policy/Cont Claims Procedures	Initial	61.200
Closed CP	ract/Fratern for Accident		
04/08/2010	al Insurance		

<i>SERFF Tracking Number:</i>	<i>JEPT-126576276</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Lincoln National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45382</i>
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<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Accident 2010/</i>		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41- Closed AMEND.OT 04/08/2010 JADI	Policy/Cont Policy Amendment ract/Fratern (Off the Job Accident al Disability Benefit)	Initial	58.300
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41- Closed AMEND.SA 04/08/2010 OTJADI	Policy/Cont Policy Amendment ract/Fratern (Sickness and Off the al Job Accident Certificate: Disability Benefit)	Initial	59.100
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41- Closed AMEND.SH 04/08/2010 CB	Policy/Cont Policy Amendment ract/Fratern (Sickness Hospital al Confinement Benefit)	Initial	60.000
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL41- Closed AMEND.HL 04/08/2010 THA	Policy/Cont Policy Amendment ract/Fratern (Health Assessment al Benefit)	Initial	50.600
	Certificate:		
	Amendmen		

SERFF Tracking Number:	JEPT-126576276	State:	Arkansas
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TOI:	H02G Group Health - Accident Only	Sub-TOI:	H02G.000 Health - Accident Only
Product Name:	Group Accident		
Project Name/Number:	Accident 2010/ t, Insert Page, Endorseme nt or Rider		
Approved- Closed 04/08/2010	GL41- AMEND	Policy/Cont Policy Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 51.300 GL41- AMEND.pdf
Approved- Closed 04/08/2010	GL42-1-FP AR	Certificate Face Page Amendmen t, Insert Page, Endorseme nt or Rider	Initial 50.700 1FPAR.pdf
Approved- Closed 04/08/2010	GL42-2-TC	Certificate Table of Contents Amendmen t, Insert Page, Endorseme nt or Rider	Initial 0.000 2TC.pdf
Approved- Closed 04/08/2010	GL42-3-SB	Certificate Schedule of Benefits Amendmen t, Insert Page, Endorseme nt or Rider	Initial 62.400 3SB.pdf
Approved- Closed 04/08/2010	GL42-4-DF AR	Certificate Definitions Amendmen t, Insert Page, Endorseme nt or Rider	Initial 50.600 4DFAR.pdf
Approved- Closed 04/08/2010	GL42-5-GP	Certificate General Provisions	Initial 60.100 5GP.pdf

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<i>Product Name:</i>	<i>Group Accident</i>		
<i>Project Name/Number:</i>	<i>Accident 2010/</i>		
Closed	Amendmen		
04/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL42-6-	Certificate Eligibility and	Initial	52.500
Closed ELE	Amendmen Effective Dates for		6ELE.pdf
04/08/2010	t, Insert Personal Accident		
	Page, Insurance		
	Endorseme		
	nt or Rider		
Approved- GL42-7-TE	Certificate Termination of	Initial	51.000
Closed	Amendmen Dependent Accident		7TE.pdf
04/08/2010	t, Insert Insurance		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL42-8-	Certificate Eligibility for	Initial	60.300
Closed ELD AR	Amendmen Dependent Accident		8ELD AR.pdf
04/08/2010	t, Insert Insurance		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL42-9-TD	Certificate Termination of	Initial	75.000
Closed	Amendmen Dependent Accident		9TD.pdf
04/08/2010	t, Insert Insurance		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL42-12-	Certificate Emergency Care	Initial	56.700
Closed ECB	Amendmen Benefits		12ECB.pdf
04/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- GL42-13-	Certificate Treatment Care	Initial	62.300
Closed TCB	Amendmen Benefits		13TCB.pdf
04/08/2010	t, Insert		

<i>SERFF Tracking Number:</i>	<i>JEPT-126576276</i>	<i>State:</i>	<i>Arkansas</i>			
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<i>Project Name/Number:</i>	<i>Accident 2010/</i>					
	<i>Page,</i>					
	<i>Endorseme</i>					
	<i>nt or Rider</i>					
Approved- Closed 04/08/2010	GL42-14- SIT	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Specific Injuries or Treatments	Initial	65.100	14SIT.pdf
Approved- Closed 04/08/2010	GL42-15- TRNCB	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Transitional Care Benefits	Initial	59.800	15TRNCB.pdf
Approved- Closed 04/08/2010	GL42-16- ADD	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Accidental Death & Dismemberment (AD&D) Benefits	Initial	50.800	16ADD.pdf
Approved- Closed 04/08/2010	GL42-16- DSMBR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Accidental Dismemberment Benefits	Initial	52.100	16DSMBR.pdf
Approved- Closed 04/08/2010	GL42-17- EX AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Limitations and Exclusions	Initial	50.600	17EX AR.pdf
Approved- Closed 04/08/2010	GL42-18-B	Certificate Amendmen t, Insert Page, Endorseme	Beneficiary	Initial	58.600	18B.pdf

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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Accident
Project Name/Number: Accident 2010/
Closed APP.02/10 Enrollment Insurance 10.pdf
04/08/2010 Form

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana

Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

Group Policyholder: The ABC Company, Incorporated

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on Month Day, Year, and on the same day of each month after that. Policy anniversaries will be each Month Day; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

This Policy is delivered in the State of Arkansas.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is Month Day, Year.



Secretary



President

**THIS IS A LEGAL CONTRACT BETWEEN
THE POLICYHOLDER AND THE COMPANY**

READ YOUR POLICY CAREFULLY

**This is a limited benefit policy. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.**

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-423-2765]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

GROUP ACCIDENT INSURANCE POLICY

No. GL 000000000000

TABLE OF CONTENTS

Schedule of Benefits	3
Definitions.....	11
General Provisions	17
Provisions Applicable to Participating Organizations.....	19
Eligibility and Effective Dates for Personal Accident Insurance.....	20
Termination of Personal Accident Insurance	22
Eligibility for Dependent Insurance	24
Termination of Dependent Insurance	26
Premiums and Premium Rates	27
Policy Termination.....	29
Emergency Care Benefits.....	30
Treatment Care Benefits	31
Specific Injuries or Treatments	33
Transitional Care Benefits	35
Accidental [Death and] Dismemberment [(AD&D)] Benefits	37
Limitations and Exclusions	38
Beneficiary	39
Claims Procedures for Accident Insurance	41

SCHEDULE OF BENEFITS

CLASSIFICATION

[Class 1 All Full-Time Employees]

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section)

30 days of continuous Active Work

ANNUAL/OPEN ENROLLMENT PERIOD: November 1 - November 30

**SCHEDULE OF BENEFITS
(Continued)**

[BENEFITS FOR PLAN1/ CLASS 1]

ELIGIBLE CLASS means: [All Full-Time Employees]

[MINIMUM HOURS PER WEEK: 20]

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Accident Insurance.
Insured Persons are required to contribute to the cost for Dependent Accident Insurance.

**SCHEDULE OF BENEFITS
(Continued)**

EMERGENCY CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Ambulance Transportation	[\$50-500]
Air Ambulance Transportation	[\$200-2,500]
Emergency Care Treatment	[\$10-400]
Initial Physician Office Visit	[\$10-200]
Major Diagnostic Exam	[\$50 - 1,500]

TREATMENT CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Hospital Admission	[\$100-3,000]
Hospital Confinement	[\$50-1,000]
Intensive Care Unit (ICU) Confinement	[\$50-1,000]
Alternate Care and Rehabilitative Facility Confinement	[\$40-1,000]
Follow-up Care	[\$10-100]
Transportation	[\$50-900]
Lodging	[\$50-350]
Family Care	[\$10 - 200]

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
	<u>Non Surgical</u>	<u>Surgical</u>
Fractures		
Ankle	[\$50-5,000]	[\$50-5,000]
Arm (shoulder to elbow)	[\$50-5,000]	[\$50-5,000]
Arm (elbow to wrist)	[\$50-5,000]	[\$50-5,000]
Bones of Face (except those listed below)	[\$50-2,000]	[\$50-2,000]
Coccyx	[\$50-2,000]	[\$50-2,000]
Collarbone	[\$50-5,000]	[\$50-5,000]
Elbow	[\$50-5,000]	[\$50-5,000]
Finger	[\$10-2,000]	[\$10-2,000]
Foot (except toes)	[\$50-5,000]	[\$50-5,000]
Hand (except fingers)	[\$50-5,000]	[\$50-5,000]
Hip	[\$100-8,000]	[\$100-8,000]
Kneecap	[\$50-5,000]	[\$50-5,000]
Leg (hip to knee)	[\$50-5,000]	[\$50-5,000]
Leg (knee to ankle)	[\$50-5,000]	[\$50-5,000]
Lower Jaw	[\$50-5,000]	[\$50-5,000]
Nose	[\$50-2,000]	[\$50-2,000]
Pelvis	[\$50-5,000]	[\$50-5,000]
Rib	[\$50-2,000]	[\$50-2,000]
Shoulder blade	[\$50-5,000]	[\$50-5,000]
Skull (depressed)	[\$50-5,000]	[\$50-5,000]
Skull (non-depressed)	[\$50-5,000]	[\$50-5,000]
Sternum	[\$50-5,000]	[\$50-5,000]
Toe	[\$10-2,000]	[\$10-2,000]
Upper Jaw	[\$50-5,000]	[\$50-5,000]
Vertebrae	[\$50-2,000]	[\$50-2,000]
Vertebral Column	[\$50-5,000]	[\$50-5,000]
Wrist	[\$50-5,000]	[\$50-5,000]
Chip Fracture	[10-50% of the amount payable for full fracture]	
Multiple Fractures	[Highest amount of 2 – 10 fractures sustained]	

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
Dislocations	<u>Non-Surgical</u>	<u>Surgical</u>
Ankle	[\$50-5,000]	[\$50-5,000]
Collarbone (sternoclavicular)	[\$50-5,000]	[\$50-5,000]
Collarbone (acromio and separation)	[\$50-3,000]	[\$50-3,000]
Elbow	[\$50-3,000]	[\$50-3,000]
Finger	[\$10-2,000]	[\$10-2,00]
Foot (except toes)	[\$50-5,000]	[\$50-5,000]
Hand (except fingers)	[\$50-5,000]	[\$50-5,000]
Hip	[\$100-12,000]	[\$100-12,000]
Knee (not kneecap)	[\$50-5,000]	[\$50-5,000]
Lower Jaw	[\$50-5,000]	[\$50-5,000]
Shoulder	[\$50-5,000]	[\$50-5,000]
Toe	[\$10-2,000]	[\$10-2,000]
Wrist	[\$50-5,000]	[\$50-5,000]
Partial Dislocation	[10-50% of benefit payable for Dislocation]	
Multiple Dislocations	[Highest amount of 2 – 10 dislocations sustained]	
Combination of Dislocation(s) and Fracture(s)	[Highest amount of 2 - 10 dislocations or fractures sustained]	
Transfusions: Blood, Plasma, Platelets	[\$25-900]	
Burns		
<u>2nd Degree</u>		
< 9%	[\$100-800]	
10-18%	[\$100-2,500]	
19-36%	[\$200-5,000]	
37% +	[\$300-8,000]	
<u>3rd Degree</u>		
< 9%	[\$300-8,000]	
10-18%	[\$500-13,000]	
19-36%	[\$800-25,000]	
37% +	[\$1,000-50,000]	
Skin Grafts (due to burns)	[10-50% of benefit payable for Burns]	

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
Coma	[<u>\$200-15,000</u>]
Concussion	[<u>\$10-500</u>]
Dental Injury - Emergency Dental Work for the following:	
Crown	[<u>\$10-500</u>]
Extraction	[<u>\$10-300</u>]
Eye Injury	
Surgical repair	[<u>\$20-900</u>]
Removal of foreign body	[<u>\$20-700</u>]
Joint Replacement	
Hip	[<u>\$500-15,000</u>]
Knee	[<u>\$500-15,000</u>]
Shoulder	[<u>\$500-15,000</u>]
Lacerations	
No Sutures Required	[<u>\$5-500</u>]
Sutures Required (Total Length of all sutured Lacerations)	
up to 5cm:	[<u>\$10-800</u>]
5.1-15.5cm:	[<u>\$25-2,000</u>]
15.6cm+:	[<u>\$50-3,000</u>]
Knee Cartilage	[<u>\$50-2,500 per repair</u>]
Ligaments/Tendons/Rotator Cuff	[<u>\$50-2,500 per repair</u>]
Ruptured Disc	[<u>\$50-2,500</u>]
Surgery – Abdominal or Thoracic	[<u>\$100-3,000</u>]
Surgery – Arthroscopic	[<u>\$100-800</u>]

**SCHEDULE OF BENEFITS
(Continued)**

TRANSITIONAL CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Medical Appliance Assistance	
Crutches	[\$10-100]
Wheelchair – expected use less than 1 year	[\$50-250]
Wheelchair – expected use 1 year or longer	[\$200-2,000]
Walker – expected use less than 1 year	[\$10-100]
Walker – expected use 1 year or longer	[\$50-250]
Other Medical Appliance used for mobility	[\$10-100]
Prosthesis	[\$200-5,000 per device]
Reasonable Modifications	[\$500-15,000]

ACCIDENTAL [DEATH and] DISMEMBERMENT BENEFITS [AD&D]

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Loss	
Loss of Life	<u>[\$5,000-200,000]</u>
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	<u>[\$2,000-40,000]</u>
Any Loss of finger, thumb, or toe	<u>[\$50-2,500]</u>
Common Carrier Accident	<u>[1-2 times AD&D Benefit Amount/\$10,000-300,000]</u>
Common Disaster	<u>[1.5-3 times AD&D Benefit Amount]</u>
Transportation of Remains	<u>[\$3,000-20,000]</u>
Seat Belt/Helmet	<u>[5-15% of AD&D Benefit Amount]</u>
Catastrophic Loss	<u>[\$5,000-150,000]</u>
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or ACTIVELY AT WORK means an [Employee's/member's] performance of all customary duties of his or her occupation at:

- (1) the [Group Policyholder's/Participating Organization's] place of business; or
- (2) any other business location designated by the [Group Policyholder/Participating Organization.]

Unless disabled on the prior workday or on the day of absence, an [Employee/member] will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible [Employees/members] to purchase or make changes to their Personal or Dependent Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. [Change in Family Status also means the involuntary loss of comparable coverage under a spouse's benefit plan.]

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

- (1) is licensed as such by the state;
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person [or Insured Dependent] is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

DEFINITIONS
(Continued)

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:

- (1) occurs while the Insured Person's [or Insured Dependent's] coverage under this Policy is in effect;
- (2) results in an Injury; and
- (3) is not otherwise excluded under the terms of this Policy.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT ACCIDENT INSURANCE means the coverage provided by this Policy for eligible Dependents.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means [the period of time an Employee must be employed in an eligible class with the Group Policyholder/Participating Organization, before he or she becomes eligible to enroll for insurance under this Policy. The period of service must be continuous, except as explained in the Eligibility section captioned Prior Service Credit Towards Waiting Period. / means the period of time a Person must be in an eligible class with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under this Policy].

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the [Group Policyholder/Participating Organization].

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the law which applies; and
- (3) does not exceed the period approved by the [Group Policyholder or Participating Organization] and required by that law.

The leave period may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under this Policy takes effect, he or she is not considered Actively at Work.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

**DEFINITIONS
(Continued)**

FULL-TIME EMPLOYEE means a person:

- (1) whose employment with the Group Policyholder/Participating Organization is the person's main occupation;
- (2) whose employment is for regular wage or salary;
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
- (4) who is a member of an eligible class under this Policy;
- (5) who is not a temporary or seasonal employee; and
- (6) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of this Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month;

at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

DEFINITIONS (Continued)

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss benefits, means severance or loss of function:

- (1) of the hand through or above the wrist joint;
- (2) of the foot through or above the ankle joint;
- (3) of the arm above the elbow;
- (4) of the leg above the knee;
- (5) of sight in an eye, total and permanent loss of sight;
- (6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
- (7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
- (8) of a finger or a thumb; or
- (9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

DEFINITIONS
(Continued)

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

OUTPATIENT TREATMENT means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

PAYROLL PERIOD means that period of time established by the Group Policyholder/or Participating Organization for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder[:]

- [(1)] who is a member of a class that is eligible for insurance under this Policy[; and]
- [(2)] who has completed an enrollment form].

PERSONAL ACCIDENT INSURANCE means the insurance provided by this Policy for Insured Persons.

PHYSICAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's, or civil union partner's] relatives of like degree.

POLICY means this Group Accident Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

REGULAR PART-TIME EMPLOYEE means a person:

- (1) whose employment is for wage or salary;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
- (3) who is a member of a class which is eligible for insurance under this Policy;
- (4) who is not a temporary or seasonal employee; and
- (5) who is a citizen of the United States or legally works in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Organization] who is eligible for retirement benefits.

DEFINITIONS
(Continued)

SICKNESS means:

- (1) illness;
- (2) pregnancy; or
- (3) infection, except when the infection is due to an Accidental cut or wound.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) this Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participation Organization's Application or Participation Agreement.]

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by this Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent];
and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:

- (1) determine the insurability of a group or any individual within a group;
- (2) make a contract in the Company's name;
- (3) amend or waive any provision of this Policy; or
- (4) extend the time for payment of any premium.

No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) this Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

NONPARTICIPATION. This is a non-participating policy. It will not share in the divisible surplus of any Company.

INFORMATION TO BE FURNISHED. The Group Policyholder [and any Participating Organization] may be required to furnish any information needed to administer this Policy, including:

- (1) information about persons:
 - (a) who become eligible for insurance;
 - (b) whose amounts of insurance change; or
 - (c) whose eligibility or insurance ends;
- (2) occupational information and other facts that may be needed to manage a claim; and
- (3) any other information that the Company may reasonably require.

The Company may inspect the Group Policyholder's [or any Participating Organization's] records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder or any Participating Organization:

- (1) will not void or terminate insurance that otherwise would be in effect;
- (2) will not result in insurance coverage that otherwise would not be in effect; and
- (3) will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER. In administering this Policy, the Group Policyholder must:

- (1) treat [Employees/members] the same in like situations; and
- (2) allow the Company, without inquiry, to rely on its acts.

GROUP POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CERTIFICATES. The [Group Policyholder/Participating Organization] will be furnished with individual certificates of insurance for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Policy may not be assigned.

PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS

A Participating Organization has no rights under this Policy except as provided in this section. The Participating Organization will be responsible for all premiums payable with respect to any of its [Employees/members] who are Insured Persons under this Policy.

PARTICIPATING ORGANIZATION means an organization that has been approved by the Company for participation in the insurance provided by this Policy. The following are Participating Organizations:

ABC Company, Incorporated

XYZ Company, P.C.

EFFECTIVE DATE. As it applies to any Participating Organization, the Effective Date of this Policy will be the later of:

- (1) the date this Policy is issued;
- (2) the first day of the Insurance Month following the Company's approval of the organization's Participation Agreement; or
- (3) a date agreed upon by the Company, the Participating Organization, and the Group Policyholder.

TERMINATION. A Participating Organization's participation under this Policy ends on the earliest of the following dates:

- (1) the date the organization no longer meets the definition of a Participating Organization;
- (2) the date the Participating Organization suspends active business operations, is placed in bankruptcy or receivership, dissolves, merges or relocates;
- (3) the date the Participating Organization, without good cause, fails to:
 - (a) promptly furnish the Company any information it may reasonably require; or
 - (b) perform its duties pertaining to this Policy in good faith;
- (4) the last day of the Insurance Month for which premium is paid;
- (5) the last day of the Insurance Month in which the Company receives the Participating Organization's written request to cease participation; or
- (6) the date this Policy terminates.

On the day participation ends, Policy insurance will terminate for all Insured Persons of the Participating Organization [and their Insured Dependents], unless eligible under the Portability section of this Policy.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE**

ELIGIBILITY. A Person becomes eligible for insurance provided by this Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date such Person's organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed.]

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

- (1) a [former employee/member] is rehired within one year after his or her employment ends; or
- (2) [an employee/a member] returns from an approved Family or Medical Leave within:
 - (a) the leave period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (3) [an employee/a member] returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

- (1) when first eligible[; or]
- (2) during any Annual/Open Enrollment Period[; or]
- (3) within 31 days following a qualifying Change In Family Status.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

- (1) the date the Person becomes eligible for the insurance;
- (2) the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible. The Person will be deemed Actively at Work on any regular non-working day, if he or she:
 - (a) is not totally disabled or Hospital confined on that day; and
 - (b) was Actively at Work on the regular working day before that day; or
- (3) if the Person contributes to the cost of the Personal Accident Insurance, the date the Person makes written application for insurance[; and signs:]
 - [(a) a payroll deduction order, if Insured Persons pay any part of the Policy premium for Personal Accident Insurance; or]
 - [(b) an order to pay premiums from the Person's Section 125 Plan account, if any contributions are paid through a Section 125 Plan;and pays the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase, if Actively at Work on that day; or
- (2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change, whether or not the Insured Person is Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE

REINSTATEMENT RIGHTS. If an Insured Person's insurance terminates due to one of the following breaks in service [or a reduction in hours], he or she will be entitled to reinstate the insurance upon resuming Active Work with the [Group Policyholder/Participating Organization] within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

- (1) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (2) return from a Military Leave within the period required by federal USERRA law[; or]
- (3) return from any other approved leave of absence within 12 months after the leave begins[; or]
- (4) return within one year following a lay off[; or]
- (5) return within one year following termination of employment for any other reason[; or]
- (6) return to an eligible class following a reduction in hours.

To reinstate insurance coverage, the Person must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class [unless the Group Policyholder/Participation Organization contributes the entire cost of the premium]. The required premium payments must be received from the Group Policyholder/Participation Organization for coverage to be reinstated. Reinstatement will take effect on the date the Person returns to Active Work.

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. An Insured Person's insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date this Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination.);
- (2) the date the Insured Person's Class is no longer eligible for insurance;
- (3) the date the Insured Person ceases to be a member of the Eligible Class;
- (4) the last day of the Insurance Month in which the Insured Person requests termination;
- (5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
- (6) the end of the period for which the last required premium has been paid;
- (7) with respect to any particular insurance benefit, the date the portion of this Policy providing that type of benefit terminates;
- (8) the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates; or
- (9) the date the Insured Person enters armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Person sends proof of military service, the Company will refund any unearned premium.); unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work [or reduction of Minimum Hours] results in termination of the Insured Person's eligibility for insurance, but insurance may be continued as follows.

Disability. If the Insured Person is disabled due to illness or Injury, then insurance may be continued until [the earlier of:]

- [(1) 12 Insurance Months after the disability begins;] [or]
- [(2) the date the Person is no longer disabled.]

The required premium payments must be received from the [Group Policyholder/Participating Organization], throughout the period of continued insurance[, unless premium is waived below].

[If the Insured Person is disabled for at least 30 days due to an Injury as a result of a Covered Accident, premium payments for Personal Accident Insurance and any Dependent Accident Insurance will be waived:

- (1) from the first premium due date following the last day worked;
- (2) until the Insured Person is no longer disabled.

If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.]

Family or Medical Leave. If an Insured Person goes on an approved Family or Medical Leave and is **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

- (1) the end of the leave period approved by the [Group Policyholder/Participating Organization];
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date the Insured Person notifies the [Group Policyholder/Participating Organization] that he or she will not return; or
- (4) the date the Insured Person begins employment with another employer.

The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Military Leave If an Insured Person goes on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the [Group Policyholder/Participating Organization]. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

TERMINATION OF PERSONAL ACCIDENT INSURANCE
(Continued)

Lay Off or Other Leave. When an Insured Person ceases work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued until the end of the Insurance Month following the month in which the lay off or leave begins. The required premiums must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Temporary Reduction in Hours. When an Insured Person's hours are temporarily reduced resulting in his or her loss of eligibility under this Policy, insurance may be continued for six Insurance Months after the temporary reduction in hours begins, provided the Insured Person works at least 30 hours in a two-week period. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Conditions. In administering the above continuations, the [Group Policyholder/Participating Organization] must not act so as to discriminate unfairly among Insured Persons in similar situations. [Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.]

PORTABILITY. If insurance under this Policy would end for any reason other than nonpayment of premiums, the Insured Person has the option to continue Personal Accident Insurance and Dependent Accident Insurance. To continue insurance under this section, the Insured Person must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because an Insured Person's spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which the Insured Person paid premiums; or
- (2) the date the Company receives a written request from the Insured Person to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Person was insured under this Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE

DEPENDENT means an Insured Person's:

- (1) legal spouse, who is not legally separated from the Insured Person;
- (2) unmarried child less than 19 years of age; [or]
- [(3) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (4) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon the Insured Person for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the Dependent rate.

[Dependent will also include a child that is required to be provided insurance by the Insured Person under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) an Insured Person 's natural child or legally adopted child;
- (2) a child placed under the Insured Person's charge, care or control for whom the Insured Person has filed a petition to adopt, from:
 - (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
 - (b) the date of the filing of a petition for adoption, if the Insured Person applies for coverage within 60 days after the filing of the petition for adoption;
- (3) a child for whom the Insured Person is required by court order to provide Accident insurance;
- (4) a stepchild [or grandchild] who resides in the Insured Person's household; and who is chiefly dependent on the Insured Person for support; and
- (5) a foster child:
 - (a) who resides in the Insured Person's household;
 - (b) who is chiefly dependent on the Insured Person for support; and
 - (c) for whom the Insured Person has assumed full parental responsibility and control.

ELIGIBILITY. An Insured Person becomes eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date the Insured Person becomes eligible for Personal Accident Insurance;
- (2) the issue date of this Policy; or
- (3) the date the Insured Person first acquires a Dependent.

An Insured Person again becomes eligible to enroll for Dependent Accident Insurance under this Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual/Open Enrollment Period.

A Person must be insured for Personal Accident Insurance to insure his or her Dependents. [Dependents to be insured by this Policy must be enrolled in the same plan of benefits as the Insured Person.]

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Accident Insurance will become effective on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date the Insured Person becomes eligible for Dependent Accident Insurance; or
 - (2) the first day of the Insurance Month coinciding with or next following the date the Insured Person makes written application for Dependent Accident Insurance; [and, if additional premium is required, the Insured Person signs:]
 - [(a) a payroll deduction order, if the Insured Person pays any part of the premium for Dependent Accident Insurance; or]
 - [(b) an order to pay premiums from the Insured Person's Section 125 Plan account, if any contributions for Dependent Accident Insurance are paid through a Section 125 Plan account;]
- and pays the required Dependent premium to the Company.

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires the Insured Person to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) the Insured Person completes a written application; and
- (2) [a payroll deduction order or Section 125 Plan election is made and] the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If an Insured Person acquires a newborn Dependent child, the child will be automatically insured for the first 90 days following birth. If the Insured Person elects not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's insurance will terminate.

**TERMINATION OF
DEPENDENT ACCIDENT INSURANCE**

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in this Policy.

Dependent Accident Insurance will cease for all of the Insured Person's Dependents on the earliest of:

- (1) the date the Insured Person's Accident Insurance terminates;
- (2) the date Dependent Accident Insurance is discontinued under this Policy;
- (3) the date the Insured Person ceases to be in a class eligible for Dependent Accident Insurance;
- (4) the date the Insured Person requests that the Dependent Accident Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of this Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Accident Insurance terminates due to the Insured Person's death, Dependent Accident Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the [Group Policyholder/Participation Organization] submits the premium on behalf of the surviving Dependents; and this Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If an Insured Person reinstates his or her Personal Accident Insurance, the Insured Person may also reinstate Dependent's Accident Insurance at the same time. To do so, the Insured Person must follow the same requirements that apply in the reinstatement of the Insured Person's Personal Accident Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under this Policy.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No insurance provided by this Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The [Group Policyholder/Participating Organization] is responsible for paying all premiums as they become due.

GRACE PERIOD. A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the [Group Policyholder/Participating Organization] gives the Company advance written notice of termination. [The Group Policyholder/Participating Organization] will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

PREMIUM RATE CHANGE. The Company may change any premium rate:

- (1) the date this Policy's terms are changed; or
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Company's liability is changed because the [Group Policyholder/Participating Organization] (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy; or
- (4) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company, for all policies of like class.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the total of the premium amounts obtained by multiplying:

- (1) each rate shown in the Premium Rate Schedule; by
 - (2) the number of Insured Persons electing each rate[;]
- [and then adding the monthly billing fee, if any].

For premium purposes, the effective date of any change in insurance is the first day of the Insurance Month which coincides with or follows the change. Changes will not be pro-rated daily.

PREMIUM RATE SCHEDULE

Monthly Accident Rates

Plan 1

Personal Accident Only insurance	\$.xx
Personal Accident and Dependent Spouse insurance	.zz
Personal Accident and Dependent Children insurance	
Personal Accident and Dependent (Spouse & Children) insurance	

Plan 2

Personal Accident Only insurance	\$.aa
Personal Accident and Dependent (Spouse & Children) insurance	.bb

POLICY TERMINATION

TERMINATION BY THE COMPANY. This Policy is issued for an indefinite term. The Policy will continue in force as long as premiums are paid when due, unless terminated for one of the following reasons:

- (1) the Group Policyholder [or Participating Organization], without good cause, fails to:
 - (a) promptly furnish any information which the Company may reasonably require;
or
 - (b) perform its duties pertaining to this Policy in good faith; or
- (2) state law otherwise requires this Policy to be terminated.

To terminate this Policy, the Company must give the Group Policyholder [or Participating Organization] at least 31 days' advance written notice of its intent to do so

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Insurance will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

EMERGENCY CARE BENEFITS
[For Plan/Class 1]

The Company will pay [one or more of] the following emergency care benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person [or Insured Dependent] by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person [or Insured Dependent] by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if an Insured Person [or Insured Dependent] is examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if an Insured Person [or Insured Dependent] is examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if an Insured Person [or Insured Dependent] receives payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if an Insured Person [or Insured Dependent] undergoes one of the following major diagnostic exams as a result of a Covered Accident:

- (1) a computed tomography (CT or CAT) scan;
- (2) a magnetic resonance imaging (MRI);
- (3) a positron emission tomography (PET) scan;
- (4) an electroencephalography (EEG);
- (5) a spectroscopy (SPECT);
- (6) a joint imaging scan;
- (7) a diffusion tensor imaging (DTI) scan; or
- (8) a magnetic resonance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS
[For Plan/Class 1]

The Company will pay [one or more of] the following treatment care benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if an Insured Person [or Insured Dependent] is admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day an Insured Person [or Insured Dependent] is confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day an Insured Person [or Insured Dependent] is confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If an Insured Person [or Insured Dependent] exhausts the ICU benefit but is still confined, the Insured Person [or Insured Dependent] may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care and Rehabilitative Facility Confinement benefit for each day an Insured Person [or Insured Dependent] is confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that results from Injuries sustained by an Insured Person [or Insured Dependent]. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while the Insured Person [or Insured Dependent] is confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when the Insured Person [or Insured Dependent] must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

TREATMENT CARE BENEFITS

(Continued)

[For Plan/Class 1]

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies an Insured Person [or Insured Dependent] who is Hospital confined more than 100 miles from the Insured Person's [or Insured Dependent's] principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care benefit if:

- (1) an Insured Person [or Insured Dependent] is confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) the Insured Person has a child or children attending a Child Care Center.

The benefit is payable for each child attending a Child Care Center on any given day the Insured Person [or Insured Dependent] is confined. The child attending a Child Care Center does not need to be insured under this Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIFIC INJURIES OR TREATMENTS
[For Plan/Class 1]

The Company will pay [one or more of] the following specific injuries or treatments benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when an Insured Person [or Insured Dependent] sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when an Insured Person [or Insured Dependent] sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for an Insured Person's [or Insured Dependent's]:

- (1) transfusion;
- (2) administration;
- (3) cross-matching; or
- (4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when an Insured Person [or Insured Dependent] sustains a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if an Insured Person [or Insured Dependent] has been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if the Insured Person [or Insured Dependent] sustains a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if an Insured Person's [or Insured Dependent's] natural teeth are damaged and:

- (1) extracted; or
- (2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS

(Continued)

[For Plan/Class 1]

EYE INJURY. The Company will pay an Eye Injury benefit if an Insured Person [or Insured Dependent] injures an eye (or eyes) in a Covered Accident and:

- (1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
- (2) a Physician removes an embedded foreign body from the Insured Person's [or Insured Dependent's] eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when an Insured Person [or Insured Dependent] sustains an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when an Insured Person [or Insured Dependent] sustains a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

- (1) once for lacerations not requiring sutures, regardless of the number; and
- (2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when an Insured Person [or Insured Dependent] sustains an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when an Insured Person [or Insured Dependent] requires surgical repair of:

- (1) tendons;
- (2) ligaments; or
- (3) the muscles or tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when an Insured Person [or Insured Dependent] sustains an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when an Insured Person [or Insured Dependent] undergoes abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when an Insured Person [or Insured Dependent] undergoes arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

[For Plan/Class 1]

The Company will pay [one or more of] the following transitional care benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by an Insured Person [or Insured Dependent] as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Medical Appliance must be recommended by a Physician or Medical Health Professional and received within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by an Insured Person [or Insured Dependent] as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to an Insured Person's [or Insured Dependent's]:

- (1) principal place of residence; or
- (2) vehicle;

provided the Insured Person [or Insured Dependent] suffers a Catastrophic Loss, as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS
[For Plan/Class 1]

The Company will pay [one or more of] the following AD&D benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when an Insured Person [or Insured Dependent] sustains an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when an Insured Person [or Insured Dependent] sustains a Common Carrier Accident that results in the Insured Person's [or Insured Dependent's] death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if the Insured Person [or Insured Dependent] dies at least 100 miles from his or her principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

- (1) by a company that provides mortuary transport services; and
- (2) to a mortuary or funeral home within 30 miles of the deceased Insured Person's [or Insured Dependent's] principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of an Insured Person's remains will be paid in accord with the Beneficiary provision. [A benefit payable for the transportation of an Insured Dependent's remains will be paid to the Insured Person.]

SEAT BELT/HELMET. If an Insured Person [or Insured Dependent]:

- (1) was wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffers an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both the Insured Person and Insured Dependent Spouse:

- (1) are Injured in the same Covered Accident; and
- (2) lose their lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases the Insured Dependent Spouse's benefit for Accidental loss of life to equal the Insured Person's Accidental Death benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when an Insured Person [or Insured Dependent] sustains an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

ACCIDENTAL DISMEMBERMENT BENEFITS
[For Plan/Class 1]

The Company will pay [one or more of] the following accidental dismemberment benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DISMEMBERMENT. The Company will pay an Accidental Dismemberment benefit when an Insured Person [or Insured Dependent] sustains an Injury that causes a dismemberment as a result of a Covered Accident. The Injury must cause dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss

The Accidental Dismemberment benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when an Insured Person [or Insured Dependent] sustains a Common Carrier Accident that results in the Insured Person's [or Insured Dependent's] dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

SEAT BELT/HELMET. If an Insured Person [or Insured Dependent]:

- (1) was wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffers an Accidental Dismemberment;

the Accidental Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when an Insured Person [or Insured Dependent] sustains an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

LIMITATIONS AND EXCLUSIONS
[For Plan/Class 1]

This Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

- (1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
- (2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
- (3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (4) participation in, commission of or attempt to commit a felony;
- (5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
- (6) duty as a member of any military, including Reserves or National Guard;
- (7) travel or flight in or on any Aircraft, except:
 - (a) as a fare-paying passenger on a regularly scheduled commercial flight; [or
 - (b) as a passenger or pilot in the Group Policyholder's or Participating Organization's aircraft while flying on the Group Policyholder's or Participating Organization's business provided:
 - (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
 - (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft];
- (8) the Insured Person [or Insured Dependent] having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
- [(9) Injury arising out of or in the course of any employment for wage or profit];
- (10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (11) cosmetic or elective surgery;
- (12) being incarcerated in any type of penal or detention facility;
- (13) participating in or practicing for, or officiating any semi-professional or professional sport;
- (14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If no named Beneficiary survives the Insured Person, payment will be made to the Insured Person's estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of the Insured Person's death; and
- (2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment form, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to the Insured Person's death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of the Insured Person or Beneficiary;
- (2) a person who has incurred expense as a result of the Insured Person's last illness or death;
- (3) the personal representative of the Insured Person's estate; or
- (4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) the Insured Person's name, address and certificate number, if available; and
- (3) the patient's name and relationship to the Insured Person.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Person may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of the Insured Person's life will be paid in accord with the Beneficiary provision. All other benefits will be paid to the Insured Person.

[Other] Accident Benefits. Any [other] Accident benefits will be paid to the Insured Person; unless[:]
[(1)] an overpayment has been made and the Company is entitled to reduce future benefits[: or]
[(2)] state or federal law requires that benefits be paid to a Insured Dependent child's custodial parent or custodian.]

CLAIM PROCEDURES FOR ACCIDENT INSURANCE (Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of [a death] [or other/an] Accident claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of [a death] [or other/an] Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of [a death] [or other/an] Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under this Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For [a death] [or other/an] Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the Insured Person a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Group Policyholder, the Company has the authority to:

- (1) manage this Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

POLICY AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Policy is amended by the addition of the following Off the Job Accident Disability Benefit provision.

OFF THE JOB ACCIDENT DISABILITY BENEFIT

[The Off the Job Accident Disability Benefit will apply if elected by the Insured Person and the required premium is paid.]

SCHEDULE OF BENEFITS

[ELIGIBLE CLASS: All Full-Time Employees]

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

MONTHLY BENEFIT AMOUNT FOR INSURED PERSON: \$400-1500

[MONTHLY BENEFIT AMOUNT FOR INSURED DEPENDENT SPOUSE: \$400-1500]

MAXIMUM BENEFIT PERIOD: 6 months

ELIMINATION PERIOD: [0 days for Inpatient Hospitalization; and]
0 days for Total Disability caused by Injury

DISABILITY BENEFIT. The Company will pay the Monthly Benefit Amount shown in the Schedule of Benefits above if an Insured Person [or Insured Dependent Spouse] becomes Totally Disabled as a result of an Injury sustained in a Covered Accident. The Covered Accident must occur and the Total Disability must begin while the Insured Person [or Insured Dependent Spouse] is covered under this Policy Amendment. Total Disability must begin:

- (1) within 90 days of the Injury; and
- (2) before the Totally Disabled Insured Person [or Insured Dependent Spouse] attains [age 70/his or her Social Security Normal Retirement Age (SSNRA)].

No benefit is payable during the Elimination Period. The Company must receive written proof of the Insured Person's [or Insured Dependent Spouse's] Total Disability before benefits are payable. After the Elimination Period has been met, the Company will pay the monthly benefit at the end of the month for which it is due. For any period of Total Disability which is less than one full month and for which this benefit is payable, 1/30th of the Monthly Benefit Amount will be paid for each day in such period. Benefits will be paid up to the Maximum Benefit Period shown in the Schedule of Benefits above.

RECURRENT DISABILITY. The Company will treat a Recurrent Disability as part of the prior claim if:

- (1) the Insured Person [or Insured Dependent Spouse] has the capability to return to employment; and
- (2) the Recurrent Disability begins within 90-180 days of the end of the prior claim.

The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The Recurrent Disability will be subject to the remaining Maximum Benefit Period that began under the prior claim.

**POLICY AMENDMENT
(Continued)**

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which Total Disability Benefits under this Policy Amendment are payable.

- (1) If an Insured Person [or Insured Dependent Spouse] is Totally Disabled [for at least 30 days], premium payments [for the Accident Insurance Policy/for this Policy Amendment] will be waived:
 - (a) from the first premium due date following the satisfaction of the Elimination Period;
 - (b) until the end of any period for which benefits are payable.
- (2) If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Policy.

Elimination Period means a period of continuous Total Disability that must be satisfied before an Insured Person [or Insured Dependent Spouse] is eligible to receive benefits. The Elimination Period begins on the first day of the Total Disability. The Elimination Period is shown on the Schedule of Benefits.

Insured Dependent Spouse means the Insured Person's spouse[, domestic partner, or civil union partner] for whom coverage is in effect under this Policy Amendment.

Recurrent Disability means a Total Disability caused by an Injury which is the same as, or related to, the cause of a prior Total Disability for which Monthly Benefits were payable.

Social Security Normal Retirement Age (SSNRA) means the Insured Person's [or Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

Total Disability or Totally Disabled means an Insured Person [or Insured Dependent Spouse]:

- (1) is unable, due to an Injury, to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience;
- (2) is not engaged in any employment for wage or profit; and
- (3) is under the regular care of a Physician, unless the Insured Person's [or Insured Dependent Spouse's] Physician states that no further treatment is needed.

EXCLUSIONS. The Exclusions contained in the Policy apply to this Policy Amendment. [In addition, no Benefits will be paid for any Total Disability caused by, contributed to by, or resulting from an Injury arising out of or in the course of any employment for wage or profit.]

**POLICY AMENDMENT
(Continued)**

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Policy.

Notice of Claim. Written notice of a Total Disability claim must be given within 20 days after the Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) the Insured Person's name, address, and certificate number, if available[; and]
- [(3) the Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, the Insured Person may send the Company written proof of Total Disability in a letter.

Proof of Total Disability. The Company must receive written proof of Total Disability within 90 days after the end of the Elimination Period. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time.

Proof of Total Disability must be provided at the claimant's own expense. It must show the date the Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a signed authorization for the Company to obtain more information; and
- (4) any other items the Company may reasonably require in support of the claim.

Proof of continued Total Disability and regular care of a Physician must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

Examination. The Company may have the claimant examined:

- (1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has [, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "Good Cause" means completing the exam would seriously jeopardize the Insured Person's [or Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

Time of Payment of Claims. Benefits payable under this Policy Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

- (1) Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
- (2) Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

**POLICY AMENDMENT
(Continued)**

To Whom Payable. All Total Disability benefits are payable to the Insured Person [or Insured Dependent Spouse], while living. After the Insured Person's death, such benefits will be payable in accord with the Beneficiary provision of the Policy. [After the Insured Dependent Spouse's death, such benefits will be paid to the Insured Person.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the Insured Person may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception to Claim Decision Delay Notice: The Company may need more information from the claimant to process a Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

Review Procedure. Within 180 days after receiving a denial notice for a Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

**POLICY AMENDMENT
(Continued)**

Exception to Review Decision Delay Notice: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Right Of Recovery. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage this Policy Amendment and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy Amendment.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy Amendment and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

**POLICY AMENDMENT
(Continued)**

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Policy Amendment. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, reading "Chas A. Brawley", is written over a horizontal line. The signature is enclosed within a rectangular box.

Officer of the Company

POLICY AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Policy is amended by the addition of the following Sickness and Off the Job Accident Disability Benefit provision.

SICKNESS AND OFF THE JOB ACCIDENT DISABILITY BENEFIT

[The Sickness and Off the Job Accident Disability Benefit will apply if elected by the Insured Person and the required premium is paid.]

SCHEDULE OF BENEFITS

[ELIGIBLE CLASS: All Full-Time Employees]

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

MONTHLY BENEFIT AMOUNT FOR INSURED PERSON: \$1000

[MONTHLY BENEFIT AMOUNT FOR INSURED DEPENDENT SPOUSE: \$600]

MAXIMUM BENEFIT PERIOD: 6 months

ELIMINATION PERIOD: [0 days for Inpatient Hospitalization;]
0 days for Total Disability caused by Accidental Injury; and
7 consecutive days for Total Disability caused by Sickness.

DISABILITY BENEFIT. The Company will pay the Monthly Benefit Amount shown in the Schedule of Benefits above if an Insured Person [or Insured Dependent Spouse] becomes Totally Disabled as a result of an Injury sustained in a Covered Accident or a Sickness. The Covered Accident must occur and the Total Disability must begin while the Insured Person [or Insured Dependent Spouse] is covered under this Policy Amendment. Total Disability must begin:

- (1) within 90 days of the Injury or Sickness; and
- (2) before the Totally Disabled Insured Person [or Insured Dependent Spouse] attains [age 70/his or her Social Security Normal Retirement Age (SSNRA)].

The Total Disability must begin while the Insured Person or [Insured Dependent Spouse] is covered under this Policy Amendment and before reaching his or her Social Security Normal Retirement Age (SSNRA). Total Disability must begin within 90 days of Injury or Sickness.

No benefit is payable during the Elimination Period. The Company must receive written proof of the Insured Person's [or Insured Dependent Spouse's] Total Disability before benefits are payable. After the Elimination Period has been met, the Company will pay the monthly benefit at the end of the month for which it is due. For any period of Total Disability which is less than one full month and for which this benefit is payable, 1/30th of the Monthly Benefit Amount will be paid for each day in such period. Benefits will be paid up to the Maximum Benefit Period shown in the Schedule of Benefits above.

**POLICY AMENDMENT
(Continued)**

RECURRENT DISABILITY. The Company will treat a Recurrent Disability as part of the prior claim, if the Insured Person [or Insured Dependent Spouse]:

- (1) has the capability to return to employment; and
- (2) the Recurrent Disability begins within 90 days of the end of the prior claim.

The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The Recurrent Disability will be subject to the remaining Maximum Benefit Period that began under the prior claim.

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which Total Disability Benefits under this Policy Amendment are payable.

- (1) If an Insured Person [or Insured Dependent Spouse] is Totally Disabled [for at least 30 days], premium payments [for the Accident Insurance Policy/for this Policy Amendment] will be waived:
 - (a) from the first premium due date following the satisfaction of the Elimination Period;
 - (b) until the end of any period for which benefits are payable.
- (2) If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Policy.

Elimination Period means a period of continuous Total Disability that must be satisfied before an Insured Person [or Insured Dependent Spouse] is eligible to receive benefits. The Elimination Period begins on the first day of the Total Disability. The Elimination Period is shown on the Schedule of Benefits.

Insured Dependent Spouse means the Insured Person's spouse[, domestic partner, or civil union partner] for whom coverage is in effect under this Policy Amendment.

Recurrent Disability means a Total Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Total Disability for which Monthly Benefits were payable.

Sickness means an illness, disease or pregnancy that results in Total Disability and which begins while an Insured Person [or Insured Dependent Spouse] is covered under this Policy Amendment.

Social Security Normal Retirement Age (SSNRA) means the Insured Person's [or Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

**POLICY AMENDMENT
(Continued)**

Total Disability or Totally Disabled means an Insured Person [or Insured Dependent Spouse]:

- (1) is unable, due to an Injury or Sickness, to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience;
- (2) is not engaged in any employment for wage or profit; and
- (3) is under the regular care of a Physician, unless the Insured Person's [or Insured Dependent Spouse's] Physician states that no further treatment is needed.

EXCLUSIONS. With the exception of the exclusion pertaining to disease, physical or mental infirmity, and Sickness, the Exclusions contained in the Policy apply to this Policy Amendment. [In addition, no Benefits will be paid for any Total Disability caused by, contributed to by, or resulting from an Injury arising out of or in the course of any employment for wage or profit.]

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Policy.

Notice of Claim. Written notice of a Total Disability claim must be given within 20 days after the Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) the Insured Person's name, address, and certificate number, if available[; and]
- [(3) the Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, the Insured Person may send the Company written proof of Total Disability in a letter.

Proof of Total Disability. The Company must receive written proof of Total Disability within 90 days after the end of the Elimination Period. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time.

Proof of Total Disability must be provided at the claimant's own expense. It must show the date the Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a signed authorization for the Company to obtain more information; and
- (4) any other items the Company may reasonably require in support of the claim.

Proof of continued Total Disability and regular care of a Physician must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

**POLICY AMENDMENT
(Continued)**

Examination. The Company may have the claimant examined:

- (1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has [, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "Good Cause" means completing the exam would seriously jeopardize the Insured Person's [or Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

Time of Payment of Claims. Benefits payable under this Policy Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

- (1) Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
- (2) Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

To Whom Payable. All Total Disability benefits are payable to the Insured Person [or Insured Dependent Spouse], while living. After the Insured Person's death, such benefits will be payable in accord with the Beneficiary provision of the Policy. [After the Insured Dependent Spouse's death, such benefits will be paid to the Insured Person.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the Insured Person may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception to Claim Decision Delay Notice: The Company may need more information from the claimant to process a Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

**POLICY AMENDMENT
(Continued)**

Review Procedure. Within 180 days after receiving a denial notice for a Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception to Review Decision Delay Notice: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

[Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.]

Right Of Recovery. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

**POLICY AMENDMENT
(Continued)**

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage this Policy Amendment and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy Amendment.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy Amendment and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Policy Amendment. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Policy is amended by the addition of the following Sickness Hospital Confinement Benefit provision.

SICKNESS HOSPITAL CONFINEMENT BENEFIT

[The Sickness Hospital Confinement Benefit will apply if elected by the Insured Person and the required premium is paid.]

SCHEDULE OF BENEFITS

[ELIGIBLE CLASS: All Full-Time Employees]

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR INSURED PERSON: \$100

[DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR INSURED DEPENDENT: \$100]

MAXIMUM BENEFIT PERIOD PER CONFINEMENT: 30 days

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement Benefit for each day an Insured Person [or Insured Dependent] is confined in a Hospital as the result of a Sickness. This benefit is payable for up to the number of days shown in the Schedule of Benefits above per person. The Hospital Confinement must begin while the Insured Person [or Insured Dependent] is covered under this Policy Amendment and before reaching [age 70/his or her Social Security Normal Retirement Age (SSNRA)]. In the event an Insured Person [or Insured Dependent] is confined for more than one Sickness at the same time, the Company will pay for only one Hospital Confinement Benefit per day.

RECURRENT HOSPITAL CONFINEMENT. The Company will treat a Recurrent Hospital Confinement as part of the prior claim, if the Insured Person [or Insured Dependent] has a Sickness that begins within 90 days of the end of the prior claim.

The Recurrent Hospital Confinement will be subject to the remaining Maximum Benefit Period under the prior claim.

DEFINITIONS. The following definitions are in addition to the definitions found in the Policy.

Hospital Confinement means an overnight registered bed patient in a Hospital. Such confinement must be medically necessary to diagnose or treat a covered Sickness. Hospital Confinement does not include confinement for a newborn child following birth, unless the newborn child has a covered Sickness.

Recurrent Hospital Confinement means a Hospital Confinement that is caused by a Sickness which is the same as, or related to, the Sickness causing the Hospital Confinement in a prior claim.

Sickness means an illness, disease or pregnancy that results in Hospital confinement and which begins while an Insured Person [or Insured Dependent] is covered under this Policy Amendment.

**POLICY AMENDMENT
(Continued)**

Social Security Normal Retirement Age (SSNRA) means the Insured Person's [or Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

EXCLUSIONS. With the exception of the exclusion pertaining to disease, physical or mental infirmity, and Sickness, the Exclusions contained in the Policy apply to this Policy Amendment. In addition, no benefits will be paid for any Hospital Confinement caused by, contributed to by, or resulting from:

- (1) Injury;
- (2) treatment for dental care or dental care procedures;
- (3) elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is a result of infection, congenital defect, or other disease; or
- (4) a Sickness arising out of or in the course of any employment for wage or profit.

[Hospital Confinement does not include confinement for a newborn child within 5 days from birth.]

PROOF. The Company must receive written proof of Hospital Confinement in accordance with the Proof of Claim section of the Claim Procedures of the Policy.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Policy Amendment. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT

**TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]**

The Policy is amended by the addition of the following Health Assessment Benefit provision.

HEALTH ASSESSMENT BENEFIT

[The Health Assessment Benefit will apply if elected by the Insured Person and the required premium is paid.]

SCHEDULE OF BENEFITS

[ELIGIBLE CLASS: All Full-Time Employees]

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

HEALTH ASSESSMENT PERIOD:	MONTH DATE through MONTH DATE
HEALTH ASSESSMENT BENEFIT:	\$50 for each Health Assessment Test performed, subject to a maximum of <u>2</u> Health Assessments per person per Health Assessment Period[; subject to the Overall Maximum(s)]
OVERALL MAXIMUM OF TESTS:	<u>6</u> [per family]
OVERALL MAXIMUM BENEFIT AMOUNT:	<u>\$300</u> [per family]

BENEFIT. The Company will pay a Health Assessment Benefit to an Insured Person [or Insured Dependent] who has a Health Assessment Test. The Health Assessment Test must be performed during the Health Assessment Period as shown in the Schedule of Benefits above, while the Insured Person's or Insured Dependent's coverage under this Policy Amendment is in effect.

**POLICY AMENDMENT
(Continued)**

DEFINITION. The following definition is in addition to the Definitions found in the Policy.

Health Assessment Test means any of the following tests:

- (1) abdominal aortic aneurysm ultrasonography;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest X-ray;
- (11) colonoscopy;
- (12) EKG;
- (13) double contrast barium enema;
- (14) fasting blood glucose test;
- (15) flexible sigmoidoscopy;
- (16) hemoccult stool analysis;
- (17) mammography;
- (18) pap smear;
- (19) PSA (blood test for prostate cancer);
- (20) serum cholesterol test to determined level of HDL and LDL;
- (21) serum protein electrophoresis (blood test for myeloma);
- (22) stress test;
- (23) thermography;
- (24) immunizations;
- (25) routine/annual physicals; or
- (24) any other preventive assessment test recommended by the American Medical Association.

PROOF. The Company must receive written proof of a Health Assessment Test, in accordance with the Proof of Claim section of the Claims Procedures in the Policy.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Policy Amendment. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT NO. 1

TO BE ATTACHED AND MADE A PART OF GROUP POLICY NO.: 000000000000

ISSUED TO: ABC Company

[It is agreed that the above policy be amended as follows.

On the Schedule of Insurance, Class 2 is deleted.]

The effective date of this Policy Amendment is October 1, 2010; but only with respect to losses incurred on or after that date. Nothing contained in this Policy Amendment shall change any of the terms and conditions of the Policy, except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Accepted by the Group Policyholder this _____ day of _____ 20____

By _____ Title _____

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL000000000000 has been issued to
The ABC Company, Incorporated
(The Group Policyholder)

The Issue Date of the Policy is Month Day, Year.

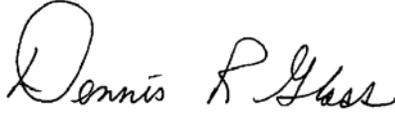
Participating Organization: XYZ Company

Participating Organization's Effective Date: _____

Certificate of Insurance for [for Plan 1/ Class 1]

[Insured Person's Name]
[Insured Person's Effective Date]
[Certificate Number]

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. [If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid.] This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.


President

READ YOUR CERTIFICATE CAREFULLY.

**This is a limited benefit certificate. It provides accident only insurance coverage.
There is no coverage for hospital, medical-surgical or major medical expenses.**

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-423-2765]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

CERTIFICATE OF GROUP ACCIDENT INSURANCE

TABLE OF CONTENTS

Schedule of Benefits	3
Definitions.....	11
General Provisions	16
Eligibility and Effective Dates for Personal Accident Insurance.....	17
Termination of Personal Accident Insurance	19
Eligibility for Dependent Insurance	21
Termination of Dependent Insurance	23
Emergency Care Benefits.....	24
Treatment Care Benefits	25
Specific Injuries or Treatments	27
Transitional Care Benefits	29
Accidental [Death and] Dismemberment [(AD&D)] Benefits	30
Limitations and Exclusions	32
Beneficiary	33
Claims Procedures for Accident Insurance	34

[ABC Company, Incorporated]
[000000000000]

SCHEDULE OF BENEFITS

[For Plan 1/ Class 1]

ELIGIBLE CLASS means: [All Full-Time Employees]

[MINIMUM HOURS PER WEEK: 20]

[ANNUAL/OPEN ENROLLMENT PERIOD: November 15 – December 14]

ELIGIBILITY WAITING PERIOD (For date insurance begins, refer to "Effective Dates" section.)

- (a) None for employees who were hired on or before the Policy Issue Date.
- (b) 30 days of continuous Active Work for employees who were hired after the Policy Issue Date.

CONTRIBUTIONS: You are required to contribute to the cost for Personal Accident Insurance and to the cost for Dependent Accident Insurance.

**SCHEDULE OF BENEFITS
(Continued)**

EMERGENCY CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Ambulance Transportation	[\$50-500]
Air Ambulance Transportation	[\$200-2,500]
Emergency Care Treatment	[\$10-400]
Initial Physician Office Visit	[\$10-200]
Major Diagnostic Exam	[\$50 - 1,500]

TREATMENT CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Hospital Admission	[\$100-3,000]
Hospital Confinement	[\$50-1,000]
Intensive Care Unit (ICU) Confinement	[\$50-1,000]
Alternate Care and Rehabilitative Facility Confinement	[\$40-1,000]
Follow-up Care	[\$10-100]
Transportation	[\$50-900]
Lodging	[\$50-350]
Family Care	[\$10 - 200]

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment

Benefit Amount

Fractures

Non Surgical

Surgical

Ankle	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (shoulder to elbow)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Arm (elbow to wrist)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Bones of Face (except those listed below)	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Coccyx	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Collarbone	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Elbow	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Finger	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Foot (except toes)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hand (except fingers)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Hip	[<u>\$100-8,000</u>]	[<u>\$100-8,000</u>]
Kneecap	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (hip to knee)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Leg (knee to ankle)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Lower Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Nose	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Pelvis	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Rib	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Shoulder blade	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Skull (non-depressed)	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Sternum	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Toe	[<u>\$10-2,000</u>]	[<u>\$10-2,000</u>]
Upper Jaw	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Vertebrae	[<u>\$50-2,000</u>]	[<u>\$50-2,000</u>]
Vertebral Column	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]
Wrist	[<u>\$50-5,000</u>]	[<u>\$50-5,000</u>]

Chip Fracture [10-50% of the amount payable for full fracture]

Multiple Fractures [Highest amount of 2 – 10 fractures sustained]

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>	
	<u>Non-Surgical</u>	<u>Surgical</u>
Dislocations		
Ankle	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Collarbone (sternoclavicular)	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Collarbone (acromio and separation)	<u>[\$50-3,000]</u>	<u>[\$50-3,000]</u>
Elbow	<u>[\$50-3,000]</u>	<u>[\$50-3,000]</u>
Finger	<u>[\$10-2,000]</u>	<u>[\$10-2,000]</u>
Foot (except toes)	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Hand (except fingers)	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Hip	<u>[\$100-12,000]</u>	<u>[\$100-12,000]</u>
Knee (not kneecap)	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Lower Jaw	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Shoulder	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Toe	<u>[\$10-2,000]</u>	<u>[\$10-2,000]</u>
Wrist	<u>[\$50-5,000]</u>	<u>[\$50-5,000]</u>
Partial Dislocation	<u>[10-50% of benefit payable for Dislocation]</u>	
Multiple Dislocations	<u>[Highest amount of 2 – 10 dislocations sustained]</u>	
Combination of Dislocation(s) and Fracture(s)	<u>[Highest amount of 2 - 10 dislocations or fractures sustained]</u>	
Transfusions: Blood, Plasma, Platelets	<u>[\$25-900]</u>	
Burns		
<u>2nd Degree</u>		
< 9%	<u>[\$100-800]</u>	
10-18%	<u>[\$100-2,500]</u>	
19-36%	<u>[\$200-5,000]</u>	
37% +	<u>[\$300-8,000]</u>	
<u>3rd Degree</u>		
< 9%	<u>[\$300-8,000]</u>	
10-18%	<u>[\$500-13,000]</u>	
19-36%	<u>[\$800-25,000]</u>	
37% +	<u>[\$1,000-50,000]</u>	
Skin Grafts (due to burns)	<u>[10-50% of benefit payable for Burns]</u>	

**SCHEDULE OF BENEFITS
(Continued)**

SPECIFIC INJURIES OR TREATMENTS (Continued)

<u>Type of Injury/Treatment</u>	<u>Benefit Amount</u>
Coma	[<u>\$200-15,000</u>]
Concussion	[<u>\$10-500</u>]
Dental Injury - Emergency Dental Work for the following:	
Crown	[<u>\$10-500</u>]
Extraction	[<u>\$10-300</u>]
Eye Injury	
Surgical repair	[<u>\$20-900</u>]
Removal of foreign body	[<u>\$20-700</u>]
Joint Replacement	
Hip	[<u>\$500-15,000</u>]
Knee	[<u>\$500-15,000</u>]
Shoulder	[<u>\$500-15,000</u>]
Lacerations	
No Sutures Required	[<u>\$5-500</u>]
Sutures Required (Total Length of all sutured Lacerations)	
up to 5cm:	[<u>\$10-800</u>]
5.1-15.5cm:	[<u>\$25-2,000</u>]
15.6cm+ :	[<u>\$50-3,000</u>]
Knee Cartilage	[<u>\$50-2,500 per repair</u>]
Ligaments/Tendons/Rotator Cuff	[<u>\$50-2,500 per repair</u>]
Ruptured Disc	[<u>\$50-2,500</u>]
Surgery – Abdominal or Thoracic	[<u>\$100-3,000</u>]
Surgery – Arthroscopic	[<u>\$100-800</u>]

**SCHEDULE OF BENEFITS
(Continued)**

TRANSITIONAL CARE BENEFITS

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Medical Appliance Assistance	
Crutches	[<u>\$10-100</u>]
Wheelchair – expected use less than 1 year	[<u>\$50-250</u>]
Wheelchair – expected use 1 year or longer	[<u>\$200-2,000</u>]
Walker – expected use less than 1 year	[<u>\$10-100</u>]
Walker – expected use 1 year or longer	[<u>\$50-250</u>]
Other Medical Appliance used for mobility	[<u>\$10-100</u>]
Prosthesis	[<u>\$200-5,000 per device</u>]
Reasonable Modifications	[<u>\$500-15,000</u>]

**SCHEDULE OF BENEFITS
(Continued)**

ACCIDENTAL [DEATH and] DISMEMBERMENT BENEFITS [AD&D]

<u>Type of Benefit</u>	<u>Benefit Amount</u>
Loss	
Loss of Life	[<u>\$5,000-200,000</u>]
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	[<u>\$2,000-40,000</u>]
Any Loss of finger, thumb, or toe	[<u>\$50-2,500</u>]
Common Carrier Accident	[<u>1-2 times AD&D Benefit Amount/\$10,000-300,000</u>]
Common Disaster	[<u>1.5-3 times AD&D Benefit Amount</u>]
Transportation of Remains	[<u>\$3,000-20,000</u>]
Seat Belt/Helmet	[<u>5-15% of AD&D Benefit Amount</u>]
Catastrophic Loss	[<u>\$5,000-150,000</u>]
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or ACTIVELY AT WORK means an [Employee's/member's] performance of all customary duties of his or her occupation at:

- (1) the [Group Policyholder's/Participating Organization's] place of business; or
- (2) any other business location designated by the [Group Policyholder/Participating Organization.]

Unless disabled on the prior workday or on the day of absence, an [Employee/member] will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

AIRCRAFT means any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible [Employees/members] to purchase or make changes to their Personal or Dependent Accident Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. [Change in Family Status also means the involuntary loss of comparable coverage under a spouse's benefit plan.]

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

- (1) is licensed as such by the state;
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person [or Insured Dependent] is a fare-paying passenger on a Common Carrier.

COMPANION means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

DEFINITIONS
(Continued)

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

COVERED ACCIDENT means an Accident that:

- (1) occurs while the Insured Person's [or Insured Dependent's] coverage under the Policy is in effect;
- (2) results in an Injury; and
- (3) is not otherwise excluded under the terms of the Policy.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

DEPENDENT ACCIDENT INSURANCE means the coverage provided by the Policy for eligible Dependents.

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means [the period of time an Employee must be employed in an eligible class with the Group Policyholder/Participating Organization, before he or she becomes eligible to enroll for insurance under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period. / means the period of time a Person must be in an eligible class with the Group Policyholder/Participating Organization, before he or she becomes eligible to enroll for insurance under the Policy.]

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the [Group Policyholder/Participating Organization].

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the Group Policyholder's [or Participating Organization's] leave policy and the law which applies; and
- (3) does not exceed the period approved by the Group Policyholder [or Participating Organization] and required by that law.

The leave period may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under the Policy takes effect, he or she is not considered Actively at Work.

FRACTURE means a broken bone that can be determined by a diagnostic exam.

**DEFINITIONS
(Continued)**

FULL-TIME EMPLOYEE means a person:

- (1) whose employment with the Group Policyholder/Participating Organization is the person's main occupation;
- (2) whose employment is for regular wage or salary;
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
- (4) who is a member of an eligible class under the Policy;
- (5) who is not a temporary or seasonal employee; and
- (6) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HOME HEALTH CARE AGENCY means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
 - (2) ending at 12:00 midnight on the last day of the same calendar month;
- at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

DEFINITIONS (Continued)

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

LOSS, as used in the Dismemberment and Catastrophic Loss benefits, means severance or loss of function:

- (1) of the hand through or above the wrist joint;
- (2) of the foot through or above the ankle joint;
- (3) of the arm above the elbow;
- (4) of the leg above the knee;
- (5) of sight in an eye, total and permanent loss of sight;
- (6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
- (7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
- (8) of a finger or a thumb; or
- (9) of a toe.

Loss of function means the total and irrevocable loss of use.

MEDICAL HEALTH PROFESSIONAL means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the Group Policyholder's [or Participating Organization's] leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

OBSERVATION UNIT means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

DEFINITIONS
(Continued)

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

OUTPATIENT TREATMENT means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

PAYROLL PERIOD means that period of time established by the Group Policyholder or Participating Organization for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder[:]

- [(1)] who is a member of a class that is eligible for insurance under the Policy[; and]
- [(2)] who has completed an enrollment form].

PERSONAL ACCIDENT INSURANCE means the insurance provided by the Policy for Insured Persons.

PHYSICAL THERAPIST means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's, or civil union partner's] relatives of like degree.

POLICY means the Group Accident Insurance policy issued by the Company to the Group Policyholder.

REGULAR PART-TIME EMPLOYEE means a person:

- (1) whose employment is for wage or salary;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
- (3) who is a member of a class which is eligible for insurance under the Policy;
- (4) who is not a temporary or seasonal employee; and
- (5) who is a citizen of the United States or legally works in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Organization] who is eligible for retirement benefits.

SICKNESS means:

- (1) illness;
- (2) pregnancy; or
- (3) infection, except when the infection is due to an Accidental cut or wound.

YOU and YOUR means an eligible [Employee/member] for whom the coverage provided by the Policy is in effect.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) the Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participation Organization's Application or Participation Agreement.]

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by the Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent];
and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) the Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE**

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date a Person's ^[JLW1] organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed.]

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

- (1) a [former employee/member] is rehired within one year after his or her employment ends; or
- (2) [an employee/a member] returns from an approved Family or Medical Leave within:
 - (a) the leave period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (3) [an employee/a member] returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

- (1) when first eligible[; or]
- (2) during any Annual/Open Enrollment Period[; or]
- (3) within 31 days following a qualifying Change In Family Status.

EFFECTIVE DATE. Personal Accident Insurance becomes effective on the latest of:

- (1) the date you become eligible for the insurance;
- (2) the date you resume Active Work, if not Actively at Work on the day you become eligible. you will be deemed Actively at Work on any regular non-working day, if you:
 - (a) are not totally disabled or Hospital confined on that day; and
 - (b) were Actively at Work on the regular working day before that day; or
- (3) if you contribute to the cost of the Personal Accident Insurance, the date you make written application for insurance[; and sign:]
 - [(a) a payroll deduction order, if you pay any part of the Policy premium for Personal Accident Insurance; or]
 - [(b) an order to pay premiums from your Section 125 Plan account, if any contributions are paid through a Section 125 Plan;and pay the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day; or
- (2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL ACCIDENT INSURANCE
(Continued)**

REINSTATEMENT RIGHTS. If your insurance terminates due to one of the following breaks in service [or a reduction in hours], you will be entitled to reinstate the insurance upon resuming Active Work with the [Group Policyholder/Participating Organization] within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

- (1) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (2) return from a Military Leave within the period required by federal USERRA law[; or]
- (3) return from any other approved leave of absence within 12 months after the leave begins[; or]
- (4) return within one year following a lay off[; or]
- (5) return within one year following termination of employment for any other reason[; or]
- (6) return to an eligible class following a reduction in hours.

To reinstate insurance coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class [unless the Group Policyholder/Participation Organization contributes the entire cost of the premium]. The required premium payments must be received from the Group Policyholder/Participation Organization for coverage to be reinstated. Reinstatement will take effect on the date you return to Active Work.

TERMINATION OF PERSONAL ACCIDENT INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date the Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination.);
 - (2) the date your Class is no longer eligible for insurance;
 - (3) the date you cease to be a member of the Eligible Class;
 - (4) the last day of the Insurance Month in which you request termination;
 - (5) the last day of the last Insurance Month for which premium payment is made on your behalf;
 - (6) the end of the period for which the last required premium has been paid;
 - (7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
 - (8) the date your employment with the Group Policyholder or Participating Organization terminates; or
 - (9) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.);
- unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work [or reduction of Minimum Hours] results in termination of your eligibility for insurance, but insurance may be continued as follows.

Disability. If you are disabled due to illness or Injury, then insurance may be continued until [the earlier of:]

- [(1) 12 Insurance Months after the disability begins;] [or]
- [(2) the date you are no longer disabled.

The required premium payments must be received from the [Group Policyholder/Participating Organization], throughout the period of continued insurance[, unless premium is waived below].

[If you are disabled for at least 30 days due to an Injury as a result of a Covered Accident, premium payments for Personal Accident Insurance and any Dependent Accident Insurance will be waived:

- (1) from the first premium due date following the last day worked;
- (2) until you are no longer disabled.

If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.]

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

- (1) the end of the leave period approved by the [Group Policyholder/Participating Organization];
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date you notify the [Group Policyholder/Participating Organization] that you will not return; or
- (4) the date you begin employment with another employer.

The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Military Leave If you go on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the [Group Policyholder/Participating Organization]. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

TERMINATION OF PERSONAL ACCIDENT INSURANCE
(Continued)

Lay Off or Other Leave. When you cease work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued until the end of the Insurance Month following the month in which the lay off or leave begins. The required premiums must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Temporary Reduction in Hours. When your hours are temporarily reduced resulting in your loss of eligibility under the Policy, insurance may be continued for six Insurance Months after the temporary reduction in hours begins, provided you work at least 30 hours in a two-week period. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Conditions. In administering the above continuations, the [Group Policyholder/Participating Organization] must not act so as to discriminate unfairly among Insured Persons in similar situations. [Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.]

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Accident Insurance and Dependent Accident Insurance. To continue insurance under this section, you must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which you paid premiums; or
- (2) the date the Company receives a written request from you to terminate the insurance.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while you were insured under the Policy.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE**

DEPENDENT means your:

- (1) legal spouse, who is not legally separated from you;
- (2) unmarried child less than 19 years of age; [or]
- [(3) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (4) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the Dependent rate.

[Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed under your charge, care or control for whom you have filed a petition to adopt, from:
 - (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
 - (b) the date of the filing of a petition for adoption, if you apply for coverage within 60 days after the filing of the petition for adoption;
- (3) a child for whom you are required by court order to provide Accident insurance;
- (4) a stepchild [or grandchild] who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Accident Insurance on the latest of:

- (1) the date you become eligible for Personal Accident Insurance;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Accident Insurance under the Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual/Open Enrollment Period.

You must be insured for Personal Accident Insurance to insure your Dependents. [Dependents to be insured by the Policy must be enrolled in the same plan of benefits as you.]

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT ACCIDENT INSURANCE
(Continued)**

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Accident Insurance will become effective on the latest of:

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| <ol style="list-style-type: none">(1) <u>the first day of the Insurance Month coinciding with or next following the date you become eligible for Dependent Accident Insurance; or</u>(2) <u>the first day of the Insurance Month coinciding with or next following the date you make written application for Dependent Accident Insurance; [and, if additional premium is required, you sign:]</u><ol style="list-style-type: none">[(a) a payroll deduction order, if you pay any part of the premium for Dependent Accident Insurance; or][(b) an order to pay premiums from your <u>Section 125 Plan</u> account, if any contributions for Dependent Accident Insurance are paid through a <u>Section 125 Plan</u> account;] <p>and pay the required Dependent premium to the Company.</p> |
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COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) [a payroll deduction order or Section 125 Plan election is made and] the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first 90 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's insurance will terminate.

TERMINATION OF DEPENDENT ACCIDENT INSURANCE

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Accident Insurance will cease for all your Insured Dependents on the earliest of:

- (1) the date your Accident Insurance terminates;
- (2) the date Dependent Accident Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class eligible for Dependent Accident Insurance;
- (4) the date you request that the Dependent Accident Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Accident Insurance terminates due to your death, Dependent Accident Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the [Group Policyholder/Participation Organization] submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If you reinstate your Personal Accident Insurance, you may also reinstate Dependent's Accident Insurance at the same time. To do so, you must follow the same requirements that apply in the reinstatement of your Personal Accident Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under the Policy.

EMERGENCY CARE BENEFITS

The Company will pay [one or more of] the following emergency care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if you [or your Insured Dependent] [are/is] examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if you [or your Insured Dependent] [are/is] examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if you [or your Insured Dependent] receive[s] payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if you or an Insured Dependent undergoes one of the following major diagnostic exams as a result of a Covered Accident:

- (1) a computed tomography (CT or CAT) scan;
- (2) a magnetic resonance imaging (MRI);
- (3) a positron emission tomography (PET) scan;
- (4) an electroencephalography (EEG);
- (5) a spectroscopy (SPECT);
- (6) a joint imaging scan;
- (7) a diffusion tensor imaging (DTI) scan; or
- (8) a magnetic resonance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

The Company will pay [one or more of] the following treatment care benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you [or your Insured Dependent] [are/is] admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a Covered Accident. The initial confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 365 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accident. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement Benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you [or your Insured Dependent] [are/is] confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you [or your Insured Dependent] exhaust[s] the ICU benefit but is still confined, you [or your Insured Dependent] may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care and Rehabilitative Facility Confinement benefit for each day you [or your Insured Dependent] [are/is] confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that result from Injuries sustained by you [or your Insured Dependent]. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while you [or your Insured Dependent] [are/is] confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you [or your Insured Dependent] must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

TREATMENT CARE BENEFITS
(Continued)

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you [or your Insured Dependent] who is Hospital confined more than 100 miles from your [or your Insured Dependent's] principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care Benefit if:

- (1) you [or your Insured Dependent] [are/is] confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
- (2) you have a child or children attending a Child Care Center.

This benefit is payable for each child attending a Child Care Center on any given day you [or your Insured Dependent] [are/is] confined. The child attending a Child Care Center does not need to be insured under the Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIFIC INJURIES OR TREATMENTS

The Company will pay [one or more of] the following specific injuries or treatments benefit[s] if you [or your Insured Dependent] meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when you or an Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when you or an Insured Dependent sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for your [or your Insured Dependent's]:

- (1) transfusion;
- (2) administration;
- (3) cross-matching; or
- (4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when you [or your Insured Dependent] sustain[s] a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn Benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn Benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if you [or your Insured Dependent] [have/has] been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if you [or your Insured Dependent] sustain[s] a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if your [or your Insured Dependent's] natural teeth are damaged and:

- (1) extracted; or
- (2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

SPECIFIC INJURIES OR TREATMENTS
(Continued)

EYE INJURY. The Company will pay an Eye Injury benefit if you [or your Insured Dependent] injure[s] an eye (or eyes) in a Covered Accident and:

- (1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
- (2) a Physician removes an embedded foreign body from your [or your Insured Dependent's] eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when you [or your Insured Dependent] sustain[s] an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when you [or your Insured Dependent] sustain[s] a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

- (1) once for lacerations not requiring sutures, regardless of the number; and
- (2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when you [or your Insured Dependent] sustain[s] an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when you [or your Insured Dependent] require[s] surgical repair of:

- (1) tendons;
- (2) ligaments; or
- (3) the muscles or tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when you [or your Insured Dependent] sustain[s] an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when you [or your Insured Dependent] undergo[es] abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when you [or your Insured Dependent] undergo[es] arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

The Company will pay [one or more of] the following transitional care benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by you [or your Insured Dependent] as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Physician or Medical Health Professional must recommend the Medical Appliance within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by you or an Insured Dependent as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to you [or your Insured Dependent's]:

- (1) principal place of residence; or
- (2) vehicle;

provided you [or your Insured Dependent] suffer[s] a Catastrophic Loss, as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The Company will pay [one or more of] the following AD&D benefit[s] if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if you [or your Insured Dependent] die[s] at least 100 miles from your [or your Insured Dependent's] principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

- (1) by a company that provides mortuary transport services; and
- (2) to a mortuary or funeral home within 30 miles of the deceased's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of your remains will be paid in accord with the Beneficiary provision. [A benefit payable for the transportation of your Insured Dependent's remains will be paid to you.]

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) suffer[s] an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both you and your Insured Dependent Spouse:

- (1) is Injured in the same Covered Accident; and
- (2) lose your lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases your Insured Dependent Spouse's benefit for Accidental loss of life to equal the your Accidental Death Benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment Benefit will not be paid for the same or attached body part.

ACCIDENTAL DISMEMBERMENT BENEFITS

The Company will pay one or more of the following accidental dismemberment benefits if you [or your Insured Dependent] meet[s] the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DISMEMBERMENT. The Company will pay an Accidental Dismemberment benefit when you [or your Insured Dependent] sustain[s] an Injury that causes a dismemberment as a result of a Covered Accident. The Injury must cause dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you [or your Insured Dependent] sustain[s] a Common Carrier Accident that results in your [or your Insured Dependent's] dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

SEAT BELT/HELMET. If you [or your Insured Dependent]:

- (1) [were/was] wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
- (2) [suffer/suffers] an Accidental Dismemberment;

the Accidental Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you [or your Insured Dependent] sustain[s] an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

LIMITATIONS AND EXCLUSIONS

The Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

- (1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
- (2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
- (3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (4) participation in, commission of or attempt to commit a felony;
- (5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
- (6) duty as a member of any military, including Reserves or National Guard;
- (7) travel or flight in or on any Aircraft, except:
 - (a) as a fare-paying passenger on a regularly scheduled commercial flight; [or
 - (b) as a passenger or pilot in the Group Policyholder's or Participating Organization's aircraft while flying on the Group Policyholder's or Participating Organization's business provided:
 - (i) the aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
 - (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him to fly the aircraft];
- (8) your [or your Insured Dependent] having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
- [(9) Injury arising out of or in the course of any employment for wage or profit];
- (10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (11) cosmetic or elective surgery;
- (12) being incarcerated in any type of penal or detention facility;
- (13) participating in or practicing for, or officiating any semi-professional or professional sport;
- (14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If no named Beneficiary survives you, payment will be made to your estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of your death; and
- (2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the Beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or a Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of services; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

Any such exam will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Accident Benefits payable under this Certificate will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of your life will be paid in accord with the Beneficiary provision. All other benefits will be paid to you.

[Other] Accident Benefits. Any [other] Accident Benefits will be paid to you; unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits; or
- [(2)] state or federal law requires that benefits be paid to an Insured Dependent child's custodial parent or custodian.]

CLAIM PROCEDURES FOR ACCIDENT INSURANCE (Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of [a death] [or other/an] Accident claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case, then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of [a death] [or other/an] Accident claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of [a death] [or other/an] Accident claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For [a death] [or other/an] Accident claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal, then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage the Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering the Policy and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's right to:

- (1) request a state insurance department review; or
- (2) bring legal action.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Off the Job Accident Disability Benefit provision.

**OFF THE JOB
ACCIDENT DISABILITY BENEFIT**

[The Off the Job Accident Disability Benefit will apply if elected by you and the required premium is paid.]

SCHEDULE OF BENEFITS

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

MONTHLY BENEFIT AMOUNT FOR YOU: \$400-1500

[MONTHLY BENEFIT AMOUNT FOR YOUR INSURED DEPENDENT SPOUSE: \$400-1500]

MAXIMUM BENEFIT PERIOD: 6 months

ELIMINATION PERIOD: [0 days for Inpatient Hospitalization; and]
0 days for Total Disability caused by Injury

DISABILITY BENEFIT. The Company will pay the Monthly Benefit Amount shown in the Schedule of Benefits above if you [or your Insured Dependent Spouse] [become/becomes] Totally Disabled as a result of an Injury sustained in a Covered Accident. The Covered Accident must occur and the Total Disability must begin while you [or your Insured Dependent Spouse] [are/is] covered under this Certificate Amendment. Total Disability must begin:

- (1) within 90 days of the Injury; and
- (2) before you [or your Totally Disabled Insured Dependent Spouse] [attain/attains] [age 70/the Social Security Normal Retirement Age (SSNRA)].

No benefit is payable during the Elimination Period. The Company must receive written proof of your [or your Insured Dependent Spouse's] Total Disability before benefits are payable. After the Elimination Period has been met, the Company will pay the monthly benefit at the end of the month for which it is due. For any period of Total Disability which is less than one full month and for which this benefit is payable, 1/30th of the Monthly Benefit Amount will be paid for each day in such period. Benefits will be paid up to the Maximum Benefit Period shown in the Schedule of Benefits above.

RECURRENT DISABILITY. The Company will treat a Recurrent Disability as part of the prior claim if:

- (1) you [or your Insured Dependent Spouse] [have/has] the capability to return to employment;
and
- (2) the Recurrent Disability begins within 90-180 days of the end of the prior claim.

The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The Recurrent Disability will be subject to the remaining Maximum Benefit Period that began under the prior claim.

**CERTIFICATE AMENDMENT
(Continued)**

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which Total Disability Benefits under this Certificate Amendment are payable.

- (1) If you [or your Insured Dependent Spouse] [are/is] Totally Disabled [for at least 30 days], premium payments [for the Accident Insurance Certificate/for this Certificate Amendment] will be waived:
 - (a) from the first premium due date following the satisfaction of the Elimination Period;
 - (b) until the end of any period for which benefits are payable.
- (2) If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Certificate.

Elimination Period means a period of continuous Total Disability that must be satisfied before you [or your Insured Dependent Spouse] [are/is] eligible to receive benefits. The Elimination Period begins on the first day of the Total Disability. The Elimination Period is shown on the Schedule of Benefits.

Insured Dependent Spouse means your spouse[, domestic partner, or civil union partner] for whom coverage is in effect under this Certificate Amendment.

Recurrent Disability means a Total Disability caused by an Injury which is the same as, or related to, the cause of a prior Total Disability for which Monthly Benefits were payable.

Social Security Normal Retirement Age (SSNRA) means your [or your Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

Total Disability or Totally Disabled means you [or your Insured Dependent Spouse]:

- (1) [are/is] unable, due to an Injury, to engage in any employment or occupation for which [you/he or she] [are/is] or [become/becomes] qualified by reason of education, training, or experience;
- (2) [are/is] not engaged in any employment for wage or profit; and
- (3) [are/is] under the regular care of a Physician, unless your [or your Insured Dependent Spouse's] Physician states that no further treatment is needed.

EXCLUSIONS. The Exclusions contained in the Certificate apply to this Certificate Amendment. [In addition, no benefits will be paid for any Total Disability caused by, contributed to by, or resulting from an Injury arising out of or in the course of any employment for wage or profit.]

**CERTIFICATE AMENDMENT
(Continued)**

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Certificate.

Notice of Claim. Written notice of a Total Disability claim must be given within 20 days after the Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address, and certificate number, if available[; and
- (3) your Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Total Disability in a letter.

Proof of Total Disability. The Company must receive written proof of Total Disability within 90 days after the end of the Elimination Period. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time. Proof of Total Disability must be provided at the claimant's own expense. It must show the date the Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a signed authorization for the Company to obtain more information; and
- (4) any other items the Company may reasonably require in support of the claim.

Proof of continued Total Disability and regular care of a Physician must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

Examination. The Company may have the claimant examined:

- (1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has [, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "**Good Cause**" means completing the exam would seriously jeopardize your [or your Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

Time of Payment of Claims. Benefits payable under this Certificate Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

- (1) Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
- (2) Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

**CERTIFICATE AMENDMENT
(Continued)**

To Whom Payable. All Total Disability benefits are payable to you [or your Insured Dependent Spouse], while living. After your death, such benefits will be payable in accord with the Beneficiary provision of the Certificate. [After your Insured Dependent Spouse's death, such benefits will be paid to you.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception to Claim Decision Delay Notice: The Company may need more information from the claimant to process a Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

Review Procedure. Within 180 days after receiving a denial notice for a Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

**CERTIFICATE AMENDMENT
(Continued)**

Exception to Review Decision Delay Notice: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

- (1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
- (2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Right of Recovery. If benefits have been overpaid on any claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

- (1) reduce future benefits and suspend payment of any other benefits under the Policy, until full reimbursement is made; ; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to manage the Certificate Amendment, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

- (1) establish administrative procedures, determine eligibility and resolve claims questions;
- (2) determine what information the Company reasonably requires to make such decisions; and
- (3) resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to the claimant's rights to request a state insurance department review or to bring legal action.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Certificate.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Certificate Amendment. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 00-0000000

ISSUED TO: ABC Company

[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Sickness and Off the Job Accident Disability Benefit provision.

**SICKNESS AND OFF THE JOB ACCIDENT
DISABILITY BENEFIT**

[The Sickness and Off the Job Accident Disability Benefit will apply if elected by you and the required premium is paid.]

SCHEDULE OF BENEFITS

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

MONTHLY BENEFIT AMOUNT FOR YOU: \$1000

[MONTHLY BENEFIT AMOUNT FOR YOUR INSURED DEPENDENT SPOUSE: \$600]

MAXIMUM BENEFIT PERIOD: 6 months

ELIMINATION PERIOD: 0 days for Inpatient Hospitalization;
0 days for Total Disability caused by Accidental Injury; and
7 consecutive days for Total Disability caused by Sickness.

DISABILITY BENEFIT. The Company will pay the Monthly Benefit Amount shown in the Schedule of Benefits above if you [or your Insured Dependent Spouse] [become/becomes] Totally Disabled as a result of an Injury sustained in a Covered Accident or a Sickness. The Covered Accident must occur and the Total Disability must begin while you [or your Insured Dependent Spouse] [are/is] covered under this Certificate Amendment. Total Disability must begin:

- (1) within 90 days of the Injury or Sickness; and
- (2) before you [or your Totally Disabled Insured Dependent Spouse] [attain/attains] [age 70/the Social Security Normal Retirement Age (SSNRA)].

No benefit is payable during the Elimination Period. The Company must receive written proof of your [or your Insured Dependent Spouse's] Total Disability before benefits are payable. After the Elimination Period has been met, the Company will pay the monthly benefit at the end of the month for which it is due. For any period of Total Disability which is less than one full month and for which this benefit is payable, 1/30th of the Monthly Benefit Amount will be paid for each day in such period. Benefits will be paid up to the Maximum Benefit Period shown in the Schedule of Benefits above.

RECURRENT DISABILITY. The Company will treat a Recurrent Disability as part of the prior claim, if you [or your Insured Dependent Spouse]:

- (1) [have/has] the capability to return to employment; and
- (2) the Recurrent Disability begins within 90 days of the end of the prior claim.

The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The Recurrent Disability will be subject to the remaining Maximum Benefit Period that began under the prior claim.

**CERTIFICATE AMENDMENT
(Continued)**

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which Total Disability Benefits under this Certificate Amendment are payable.

- (1) If you [or your Insured Dependent Spouse] [are/is] Totally Disabled [for at least 30 days], premium payments [for the Accident Insurance Certificate/for this Certificate Amendment] will be waived:
 - (a) from the first premium due date following the satisfaction of the Elimination Period;
 - (b) until the end of any period for which benefits are payable.
- (2) If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Certificate.

Elimination Period means a period of continuous Total Disability that must be satisfied before you [or your Insured Dependent Spouse] [are/is] eligible to receive benefits. The Elimination Period begins on the first day of the Total Disability. The Elimination Period is shown on the Schedule of Benefits.

Insured Dependent Spouse means your spouse[, domestic partner, or civil union partner] for whom coverage is in effect under this Certificate Amendment.

Recurrent Disability means a Total Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Total Disability for which Monthly Benefits were payable.

Sickness means an illness, disease or pregnancy that results in Total Disability and which begins while you [or your Insured Dependent Spouse] [are/is] covered under this Certificate Amendment.

Social Security Normal Retirement Age (SSNRA) means your [or your Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

Total Disability or Totally Disabled means you [or your Insured Dependent Spouse]:

- (1) [are/is] unable, due to an Injury or Sickness, to engage in any employment or occupation for which [you/he or she] [are/is] or [become/becomes] qualified by reason of education, training, or experience;
- (2) [are/is] not engaged in any employment for wage or profit; and
- (3) [are/is] under the regular care of a Physician, unless you [or your Insured Dependent Spouse's] Physician states that no further treatment is needed.

**CERTIFICATE AMENDMENT
(Continued)**

EXCLUSIONS. With the exception of the exclusion pertaining to disease, physical or mental infirmity, and Sickness, the Exclusions contained in the Certificate apply to this Certificate Amendment. [In addition, no Benefits will be paid for any Total Disability caused by, contributed to by, or resulting from an Injury arising out of or in the course of any employment for wage or profit.]

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Certificate.

Notice of Claim. Written notice of a Total Disability claim must be given within 20 days after the Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address, and certificate number, if available[; and
- (3) your Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Total Disability in a letter.

Proof of Total Disability. The Company must receive written proof of Total Disability within 90 days after the end of the Elimination Period. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time. Proof of Total Disability must be provided at the claimant's own expense. It must show the date the Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a signed authorization for the Company to obtain more information; and
- (4) any other items the Company may reasonably require in support of the claim.

Proof of continued Total Disability and regular care of a Physician must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

Examination. The Company may have the claimant examined:

- (1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has[, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "**Good Cause**" means completing the exam would seriously jeopardize your [or your Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

**CERTIFICATE AMENDMENT
(Continued)**

Time of Payment of Claims. Benefits payable under this Certificate Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

- (1) Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
- (2) Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

To Whom Payable. All Total Disability benefits are payable to you [or your Insured Dependent Spouse], while living. After your death, such benefits will be payable in accord with the Beneficiary provision of the Certificate. [After your Insured Dependent Spouse's death, such benefits will be paid to you.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception for Claim Decision Delay Notice: The Company may need more information from the claimant to process a Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

Review Procedure. Within 180 days after receiving a denial notice for a Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

**CERTIFICATE AMENDMENT
(Continued)**

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception for Review Decision Delay Notice: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

- (1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
- (2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Right of Recovery. If benefits have been overpaid on any claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

- (1) reduce future benefits and suspend payment of any other benefits under the Policy, until full reimbursement is made; ; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to manage the Certificate Amendment, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

- (1) establish administrative procedures, determine eligibility and resolve claims questions;
- (2) determine what information the Company reasonably requires to make such decisions; and
- (3) resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to the claimant's rights to request a state insurance department review or to bring legal action.

**CERTIFICATE AMENDMENT
(Continued)**

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Certificate.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Certificate Amendment. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, reading "Chas A. Brawley". The signature is written in a cursive style and is positioned above a horizontal line.

Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Sickness Hospital Confinement Benefit provision.

SICKNESS HOSPITAL CONFINEMENT BENEFIT

[The Sickness Hospital Confinement Benefit will apply if elected by you and the required premium is paid.]

SCHEDULE OF BENEFITS

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR YOU: \$100

[DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR YOUR INSURED DEPENDENT: \$100]

MAXIMUM BENEFIT PERIOD PER CONFINEMENT: 30 days

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement Benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a Sickness. This benefit is payable for up to the number of days shown in the Schedule of Benefits above per person. The Hospital Confinement must begin while you [or your Insured Dependent] [are/is] covered under this Certificate Amendment and before reaching [age 70/the Social Security Normal Retirement Age (SSNRA)]. In the event you [or your Insured Dependent] [are/is] confined for more than one Sickness at the same time, the Company will pay for only one Hospital Confinement Benefit per day.

RECURRENT HOSPITAL CONFINEMENT. The Company will treat a Recurrent Hospital Confinement as part of the prior claim, if you [or your Insured Dependent] [have/has] a Sickness that begins within 90 days of the end of the prior claim.

The Recurrent Hospital Confinement will be subject to the remaining Maximum Benefit Period that began under the prior claim.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Certificate.

Hospital Confinement means an overnight registered bed patient in a Hospital. Such confinement must be medically necessary to diagnose or treat a covered Sickness. Hospital Confinement does not include confinement for a newborn child following birth, unless the newborn child has a covered Sickness.

Recurrent Hospital Confinement means a Hospital Confinement that is caused by a Sickness which is the same as, or related to, the Sickness causing the Hospital Confinement in a prior claim.

Sickness means an illness, disease or pregnancy that results in Hospital confinement and which begins while you [or your Insured Dependent] [are/is] covered under this Certificate Amendment.

**CERTIFICATE AMENDMENT
(Continued)**

Social Security Normal Retirement Age (SSNRA) means your [or your Insured Dependent Spouse's] normal retirement age as described in the following chart:

<u>Year of Birth*</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

EXCLUSIONS. With the exception of the exclusion pertaining to disease, physical or mental infirmity, and Sickness, the Exclusions contained in the Certificate apply to this Certificate Amendment. In addition, no benefits will be paid for any Hospital Confinement caused by, contributed to by, or resulting from:

- (1) Injury;
- (2) treatment for dental care or dental care procedures;
- (3) elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is a result of infection, congenital defect, or other disease; or
- (4) a Sickness arising out of or in the course of any employment for wage or profit.

[Hospital Confinement does not include confinement for a newborn child within 5 days from birth.]

PROOF. The Company must receive written proof of Hospital Confinement in accord with the Proof of Claim section under the Claim Procedures of the Certificate.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Certificate.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Certificate Amendment. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 00-0000000

ISSUED TO: ABC Company

[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Health Assessment Benefit provision.

HEALTH ASSESSMENT BENEFIT

[The Health Assessment Benefit will apply if elected by you and the required premium is paid.]

SCHEDULE OF BENEFITS

[NAME OF INSURED: John Doe]

[EFFECTIVE DATE: January 1, 2011]

HEALTH ASSESSMENT PERIOD:	MONTH DATE through MONTH DATE
HEALTH ASSESSMENT BENEFIT:	\$ <u>50</u> for each Health Assessment Test performed, subject to a maximum of <u>2</u> Health Assessments per person per Health Assessment Period[; subject to the Overall Maximums]
OVERALL MAXIMUM OF TESTS:	<u>6</u> [per family]
OVERALL MAXIMUM BENEFIT AMOUNT:	<u>\$300</u> [per family]

BENEFIT. The Company will pay a Health Assessment Benefit to you [or your Insured Dependent] who has a Health Assessment Test. The Health Assessment Test must be performed during the Health Assessment Period as shown in the Schedule of Benefits above, while your [or your Insured Dependent's] coverage under this Certificate Amendment is in effect.

**CERTIFICATE AMENDMENT
(Continued)**

DEFINITION. The following definition is in addition to the Definitions found in the Certificate.

Health Assessment Test means any of the following tests:

- (1) abdominal aortic aneurysm ultrasonography;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest X-ray;
- (11) colonoscopy;
- (12) EKG;
- (13) double contrast barium enema;
- (14) fasting blood glucose test;
- (15) flexible sigmoidoscopy;
- (16) hemoccult stool analysis;
- (17) mammography;
- (18) pap smear;
- (19) PSA (blood test for prostate cancer);
- (20) serum cholesterol test to determined level of HDL and LDL;
- (21) serum protein electrophoresis (blood test for myeloma);
- (22) stress test;
- (23) thermography;
- (24) immunizations;
- (25) routine/annual physicals; or
- (24) any other preventive assessment test recommended by the American Medical Association.

PROOF. The Company must receive written proof of a Health Assessment Test, in accord with the Proof of Claim section under the Claims Procedures in the Certificate.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Certificate.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later/ the date shown under the Schedule of Benefits of this Certificate Amendment. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000000000000

ISSUED TO: ABC Company

[FOR: Class 1]

[Your Certificate is amended as follows.

The Minimum Hours Per Week as shown on the SCHEDULE OF INSURANCE is amended to read:

MINIMUM HOURS PER WEEK: 30]

The effective date of this Certificate Amendment is October 1, 2010; but only with respect to losses incurred on or after that date. Nothing contained in this Certificate Amendment shall change any of the terms and conditions of the Certificate, except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

The Lincoln National Life Insurance Company

Group Insurance Service Office

8801 Indian Hills Drive

Omaha, Nebraska 68114-4066

Office Use Only ID# _____

APPLICATION FOR GROUP INSURANCE
is hereby made to **THE LINCOLN NATIONAL LIFE INSURANCE COMPANY** (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): _____

2. **Main Office Address** (physical location and group situs state):
 Street _____ City _____ State _____
 Zip _____ Phone # () _____ FAX # () _____ E-Mail Address _____
 (if available)

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

<input type="checkbox"/> Life & AD&D with Effective Date _____	<input type="checkbox"/> Voluntary Life with Effective Date _____
<input type="checkbox"/> Long Term Disability with Effective Date _____	<input type="checkbox"/> Voluntary Life & AD&D with Effective Date _____
<input type="checkbox"/> Short Term Disability with Effective Date _____	<input type="checkbox"/> Voluntary Long Term Disability with Effective Date _____
<input type="checkbox"/> Dental with Effective Date _____	<input type="checkbox"/> Voluntary Short Term Disability with Effective Date _____
<input type="checkbox"/> Accident with Effective Date _____	<input type="checkbox"/> Voluntary Dental with Effective Date _____

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): _____
 Years in Business _____ Federal Tax ID# _____

2. **Business is Organized As** (select one):
 Corporation Non-Profit Organization
 Partnership Proprietorship Other _____

3. **Financial Risk** (If Yes to any part, please explain below.)
 Yes No Has Applicant ever filed for bankruptcy?
 Yes No Does Applicant anticipate ceasing or materially reducing active business operations?
 Yes No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?
 Explanation: _____

4. **Binder payment submitted:** Amount \$ _____ (if applicable)

D. REPLACEMENT COVERAGE

Yes No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. FRAUD WARNING

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Services.

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

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

LOUISIANA & RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

OHIO: A person commits insurance fraud, if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

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

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

OTHER STATES (EXCEPT KANSAS): A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

- (a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
- (b) be issued under a group Policy or Policies in the language customarily used by the Company;
- (c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
- (d) be subject to all exclusions and limitations of the Policy; and
- (e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an [employee/member] is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active [Work/Membership] requirement. The Applicant agrees not to:

- (a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
- (b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide [employees/members] and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature _____

Signed by Applicant's Authorized Representative:

Typed or Printed Name _____

Signature _____

[License Number _____ State _____]

Typed or Printed Name _____

Title _____

State Signed _____ Date _____

Must be signed prior to Effective Date

SERFF Tracking Number: JEPT-126576276 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 45382
 Company Tracking Number:
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Accident
 Project Name/Number: Accident 2010/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/08/2010
Comments:		
Attachments:		
FL040710 Readability Cert.pdf		
FL040710 AR Accident Regulations Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	04/08/2010
Comments:		
The application to be used with this product is included for review and approval under the Forms Schedule tab.		

	Item Status:	Status Date:
Satisfied - Item: Variability Statement	Approved-Closed	04/08/2010
Comments:		
Attachment:		
FL040710 AR Appendix of Variability.pdf		

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

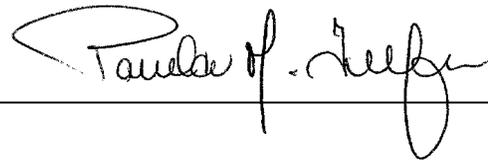
This is to certify that the forms shown below have achieved the indicated Flesch Reading Ease Score.

<u>FORM NO.</u>	<u>FLESCH SCORE</u>
GL41-1-FP AR	51.8
GL41-2-TC	N/A
GL41-3-SB	51.1
GL41-4-DF AR	50.8
GL41-5-GP	54.1
GL41-5.1-PE	55.1
GL41-6-ELE	52.3
GL41-7-TE	50.3
GL41-8-ELD AR	57.4
GL41-9-TD	64.8
GL41-10-PR	59.1
GL41-11-PT	55.9
GL41-12-ECB	56.0
GL41-13-TCB	62.4
GL41-14-SIT	64.5
GL41-15-TRNCB	54.1
GL41-16-ADD	53.6
GL41-16-DSMBR	52.6
GL41-17-EX AR	52.1
GL41-18-B	60.1
GL41-19-CP	61.2
GL41-AMEND.OTJADI	58.3
GL41-AMEND.SAOTJADI	59.1
GL41-AMEND.SHCB	60.0
GL41-AMEND.HLTHA	50.6
GL41-AMEND	51.3
GL42-1-FP AR	50.7
GL42-2-TC	n/a
GL42-3-SB	62.4
GL42-4-DF AR	50.6
GL42-5-GP	60.1
GL42-6-ELE	52.5
GL42-7-TE	51.0
GL42-8-ELD AR	60.3
GL42-9-TD	75.0
GL42-12-ECB	56.7
GL42-13-TCB	62.3
GL42-14-SIT	65.1
GL42-15-TRNCB	59.8
GL42-16-ADD	50.8

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

READABILITY CERTIFICATION (Continued)

GL42-16-DSMBR	52.1
GL42-17-EX AR	50.6
GL42-18-B	58.6
GL42-19-CP	61.7
GL42-AMEND.OTJADI	55.2
GL42-AMEND.SAOTJADI	56.1
GL42-AMEND.SHCB	55.4
GL42-AMEND.HLTHA	55.4
GL42-AMEND	51.8
GL2-APP.02/10	51.5



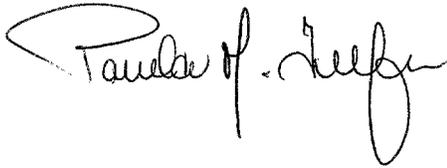
(An Officer of the Company)
Pamela M. Telfer
Assistant Vice President, Product Compliance

**Certificate of Compliance with
Arkansas Rule and Regulation 19 and 49**

Insurer: The Lincoln National Life Insurance Company

Form Number(s): GL41-1-FP AR, et al.

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rules and Regulations 19 and 49.



Signature of Company Officer

Pamela M. Telfer
Name

Assistant Vice President, Product Compliance & State Filing
Title

April 7, 2010
Date

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

APPENDIX OF VARIABILITY

For Forms:

GL41-1-FP AR	GL42-1-FP AR
GL41-2-TC	GL42-2-TC
GL41-3-SB	GL42-3-SB
GL41-4-DF AR	GL41-4-DF AR
GL41-5-GP	GL42-5-GP
GL41-5.1-PE	
GL41-6-ELE	GL42-6-ELE
GL41-7-TE	GL42-7-TE
GL41-8-ELD AR	GL42-8-ELD AR
GL41-9-TD	GL42-9-TD
GL41-10-PR	
GL41-11-PT	
GL41-12-ECB	GL42-12-ECB
GL41-13-TCB	GL42-13-TCB
GL41-14-SIT	GL42-14-SIT
GL41-15-TRNCB	GL42-15-TRNCB
GL41-16-ADD	GL42-16-ADD
GL41-16-DSMBR	GL42-16-DSMBR
GL41-17-EX AR	GL42-17-EX AR
GL41-18-B	GL42-18-B
GL41-19-CP	GL42-19-CP
GL41-AMEND.OTJADI	GL42-AMEND.OTJADI
GL41-AMEND.SAOTJADI	GL42-AMEND.SAOTJADI
GL41-AMEND.SHCB	GL42-AMEND.SHCB
GL41-AMEND.HLTHA	GL42-AMEND.HLTHA
GL41-AMEND	GL42-AMEND
GL2-APP.2/10	

The above forms are for use with Group Policy Series GL41 and Group Certificate Series GL42.

Statement of Variable Material. Variable material is denoted in the forms by underlining or bracketing. The text for the certificate is expressed in second person (you/your) language. The variability indicated in this Memorandum applies to both the policy version and certificate version of forms, unless otherwise indicated. Any alternate variations included in this memorandum that are in third person for the policy would be expressed in second person in the certificate. The following variability is requested.

The Lincoln National Life Insurance Company

I. FACE PAGES.

- A. On **policy** face page GL41-1-FP AR, we request variable filing of:
1. The underlined Group Policyholder's name, dates, premium mode, policy number, and bracketed signatures.
 2. The underlined term group insurance service office and its address.
- The underlined state of delivery will be the situs state of the group policy.
- B. On **certificate** face page GL42-1-FP AR, we request variable filing of:
1. The underlined/bracketed policy number, Group Policyholder's name, issue date, and bracketed signature.
 2. The bracketed center section of the form, so that:
 - a. "no name" certs can be issued by showing the particular applicable class number/classification;
 - b. "personalized" certs can be printed on our issuance system (by substituting the insured's name and information specific to the insured such as cert number and effective date);
 - c. specific information as it pertains to the certificate being issued may be included, such as Class number/description, Plan number/description, a Participating Organization's name (subsidiary, division, or affiliate of the Group Policyholder), Participating Organization's Effective Date; or
 - d. a sticker may be affixed in this space with the pertinent information.
 3. The underlined term group insurance service office and its address.

- II. **CONTENTS.** On Table of Contents forms GL41-2-TC and 42-2-TC we request variable filing of the entire body, so that the applicable insert page titles and page numbers can be inserted.

- III. **SCHEDULES.** Schedule forms GL41-3-SB and GL42-3-SB include hypothetical information. We request variable filing of the Schedules to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields. The variability described in items B through H may apply to both the policy form GL41-3-SB and the certificate form GL42-3-SB.

- A. In form GL42-3-SB, the following items are to be filed as variable:
1. **Group Policyholder Name** (legal name of the group)
 2. **Policy Number** (number assigned to the policy)
 3. **Plan** (if there is more than one plan: numeric or plan type/description)
 4. **Class #** (numeric: 1, 2, 3, etc./classification description)
 5. **Participating Organization** (subsidiary, division, or affiliate of Group Policyholder may be included, if applicable)
- B. **Classifications:** Class descriptions may be based upon job category or title, salary level, hours worked, years of service, union membership, exempt/nonexempt status, geographic location, date first enrolled, type of account holder/member or similar criteria.
- C. **Eligibility Waiting Period:** The eligibility waiting period can be a specific number of hours, days, or months based on continuous Active Work, continuous service, employment, continuous active member, or some other basis as provided by the Group Policyholder. It may be reflected as "None" or it can be omitted in its entirety, if not applicable.
- D. **Annual/Open Enrollment Period:** An annual or open enrollment period may be added, if applicable. The timeframe for the annual or open enrollment period is generally 30 days but may range from 30 days to 91 days.

If the Annual/Open Enrollment Period is included, the following language represents variables that may be included if there is an Open Enrollment Period. The reference to Month, Day, and Year are to be filed as variable. The type of coverage may be Personal Accident Insurance or Dependents (Spouse/Child) Accident Insurance. The underlined "day" may reflect the next day following, first day of the Insurance/calendar month coinciding with or next following, first day of the Insurance/calendar month following, the first day of the payroll cycle/pay period following, or specified day. The underlined percentages, amounts, and benefit levels will reflect the increases agreed upon by the Group Policyholder and an underwriter. Any of the bracketed items may be omitted, if not applicable.

The Lincoln National Life Insurance Company

There will be [a one time only Open Enrollment Period/ an Open Enrollment Period] beginning [January 1, 2010] and ending [January 31, 2010] for eligible employees/members to [enroll for (Personal Accident) Insurance or to change their benefit plans/amounts of (Personal Accident) Insurance]. During this enrollment period, the Insured Employee/employee/member may:

- [(1) elect(s) an amount of insurance or an increase to the Insured Person's/employee's/your current insurance amount;]
- [(2) elect(s) an increase not to exceed 1%/\$ of the Insured Person's/employee's/your current benefit level/plan;]
- [(3) elect(s) an increase of not more than one benefit level/plan option;]; and]
- [(4) enroll(s) for coverage during the Open Enrollment Period in which the Insured Person/employee/you first become(s) eligible.]

Coverage elected during this period will become effective:

- (1) [January 1st] following the enrollment period, if Actively at Work on that day; or
- (2) the day the Insured Person/employee/you resume(s) Active Work, if not Actively at Work on the day the elected [coverage or increase] would otherwise take effect.

E. **Eligible Class:** Classification description is shown, as provided by the Group Policyholder.

F. **Minimum Hours:** The minimum hours may range from 10 – 40 hours per week or may be on some other basis, such as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be reflected as per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, semester or some other specified period as provided by the group policyholder; or reflected as none or omitted entirely, if not applicable (i.e. Retirees, members).

G. **Contributions** sentence may state that:

1. insureds are or are not required to make contributions; or
2. insureds are not required to make contributions for personal coverage, but are required to do so for dependent coverage.

Example: Insured Persons are required to make contributions for Personal Accident Insurance and Dependent Accident Insurance.

To accommodate employers that include contribution statements in their Employee Handbook, ERISA plan documents or Summary Plan Description, a statement may be added following one of the above statements: See Employer/Summary Plan Description for contribution [levels or amounts].

H. **Benefits, levels, amounts:** The benefits applicable to the plan/class of insureds will be shown.

1. If Emergency Care Benefits are included, one or more of the following types of benefits may be included with the benefit amounts ranging as indicated below.
 - a. Ambulance Transportation (\$50 – 500)
 - b. Air Ambulance Transportation (\$200 – 2,500)
 - c. Emergency Care Treatment (\$10 – 400)
 - d. Initial Physician Office Visit (\$10 – 200)
 - e. Major Diagnostic Exam (\$50 – 1,500)
2. If Treatment Care Benefits are included, one or more of the following types of benefits may be included with the benefit amounts ranging as indicated below.
 - a. Hospital Admission (\$100 – 3,000)
 - b. Hospital Confinement (\$50 – 1,000)
 - c. Intensive Care Unit (ICU) Confinement (\$50-1,000)
 - d. Alternate Care and Rehabilitative Facility Confinement (\$40 – 1,000)
 - e. Follow-up Care (\$10 – 100)
 - f. Transportation (\$50 – 900)
 - g. Lodging (\$50 – 350)
 - h. Family Care (\$10 – 200)

The Lincoln National Life Insurance Company

3. If Specific Injuries or Treatments are included, one or more of the following types of benefits may be included with the benefit amounts ranging as indicated below.
 - a. Fractures
 - i. Any one or more types of fractures may be listed with the specific benefit amount for non-surgical and/or surgical treatment. The amounts may range from \$50 to \$8,000 depending on the type of fracture sustained to a particular bone.
 - ii. Chip Fracture may be a flat amount ranging from \$5 to \$4,000 or a percentage of the full fracture amount (10 – 50%).
 - iii. Multiple Fractures, if included, may reflect a flat amount up to \$8,000 or may be expressed as the highest amount of a particular number of fractures sustained (2-10 fractures).
 - b. Dislocations
 - i. Any one or more types of dislocations may be listed with the specific benefit amount for non-surgical and/or surgical treatment. The amounts may range from \$10 to \$12,000 depending on the type of dislocation sustained to a particular body part affected.
 - ii. Partial Dislocation may be a flat amount ranging from \$5 to \$6,000 or a percentage of the amount of the dislocations sustained (10 – 50%).
 - iii. Multiple Dislocations or Combination of Dislocation(s) and Fracture(s), if included, may reflect a flat amount up to \$12,000 or may be expressed as the highest amount of a particular number of dislocations and/or fractures sustained (2-10).
 - c. Transfusions: Blood, Plasma, Platelets (\$25-900)
 - d. Burns may range from \$100 to \$50,000, depending upon the degree of burn and percentage of the body burned.
 - e. Skin Grafts may be a flat amount ranging from \$10 to \$25,000 or a percentage (10 – 50%) of the benefit payable for the burns.
 - f. Coma (\$200 – 15,000)
 - g. Concussion (\$10 – 500)
 - h. Dental Injury – Emergency Dental Work for:
 - i. Crown (\$10 – 500)
 - ii. Extraction (\$10 – 300)
 - i. Eye Injury may include surgical repair and or removal of foreign body, with the amounts ranging from \$20 to \$900.
 - j. Joint Replacement
 - i. Hip (\$500 – 15,000)
 - ii. Knee (\$500 -15,000)
 - iii. Shoulder (\$500-15,000)
 - k. Lacerations
 - i. No suture benefit (\$5 – 500)
 - ii. Suture benefit based on total length of lacerations requiring sutures (\$10 – 3,000)
 - l. Knee Cartilage (\$50 – 2,500 per repair)
 - m. Ligaments/Tendons/Rotator Cuff (\$50 – 2,500 per repair)
 - n. Ruptured Disc (\$50 – 2,500)
 - o. Surgery – Abdominal or Thoracic (\$100 – 3,000)
 - p. Surgery – Arthroscopic (\$100 – 800)
4. If Transitional Care Benefits are included, one or more of the following types of benefits may be included with the benefit amounts ranging as indicated below.
 - a. Medical Appliance Assistance benefit amounts may range from \$10 to \$2,000, depending upon the type of medical appliance and expected duration for use.
 - b. Prosthesis (\$200 – 5,000 per device)
 - c. Reasonable Modifications (\$500 – 15,000)

The Lincoln National Life Insurance Company

5. Accidental Death and Dismemberment Benefits (AD&D) may be included or only Accidental Dismemberment Benefits may be included in the event a group does not want the Accidental Death benefit due to duplicative coverage with other products. We request the variability to omit the reference to "Death" and "AD&D" as well as any losses/benefits associated with accidental death if only Accidental Dismemberment Benefits are to be included. If either AD&D or Accidental Dismemberment are included, one or more of the following types of benefits may be included with the benefit amounts ranging as indicated below.
 - a. Loss may reflect the types of losses included with the amounts ranging from \$50 to \$200,000 depending on the type of loss.
 - b. Common Carrier Accident may be included if Accidental Death is included. The benefit amount may be a flat amount ranging from \$5,000 to \$400,000 or it may be a multiple of the AD&D Benefit Amount (1 – 2 times).
 - c. Common Disaster may be included if Accidental Death is included. The benefit amount may be a flat amount ranging from \$10,000 to \$600,000 or it may be a multiple of the AD&D Benefit Amount (1.5 – 3 times).
 - d. Transportation of Remains may be included if Accidental Death is included. The benefit amount may range from \$3,000 to \$20,000.
 - e. Seat Belt/Helmet may be a flat amount ranging from \$10,000 to \$50,000 or it may be a percentage (5-15%) of the AD&D/Accidental Dismemberment Benefit Amount.
 - f. Catastrophic Loss may list the losses considered to be catastrophic and the benefit amount may range from \$5,000 – 150,000)

IV. DEFINITIONS. Forms GL41-4-DF AR and GL42-4-DF AR include the following variability. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. The **ACTIVE WORK OR ACTIVELY AT WORK** definition is variable to accommodate the following situations:

1. It may be adapted to atypical work sites and schedules (such as telecommuters, academic years or union hour banks). The variable numbers underlined below are hypothetical numbers.
 - a. If the group includes atypical work sites, the Actively at Work definition may include the following item: an alternate work site at the direction of/ approved by the [Group Policyholder/Participating Organization].
 - b. If the group includes teachers, an item may be added to the days considered Actively at Work to state: a school/academic break or school/academic vacation. An Active Member definition may be included to mean a member of the Group Policyholder/Participating Organization who is employed as a teacher with a workload of at least 30% full-time during the teacher contract year.
 - c. If members are included (union, professional trade), Active Member may be included (in addition to or in lieu of the Active Work definition) to mean a member in good standing with the Group Policyholder or Participating Organization/ a member who has accumulated at least 240 contribution hours in a contribution quarter or Hour Bank/ a member who has worked 240 hours in a work quarter, work period, eligibility quarter, or eligibility period or 240 hours in a Hour Bank; who is not confined in a hospital or other health care facility on his or her eligibility date/effective date of coverage.
 - d. If members are included, Active Work may be revised to read:

ACTIVE WORK or ACTIVELY AT WORK means a member of the Group Policyholder who is engaged in employment [on a part-time/or full-time basis for the Minimum Hours shown in the Schedule of Insurance and performing all customary duties of his or her occupation].

Unless disabled on the prior workday or on the day of absence, a member will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
 - (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
 - (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.
2. The underlined references to employee/member may reflect the appropriate class of insureds in which the definition applies.
3. The bracketed references to Group Policyholder/Participating Organization may reflect either or both as applicable.

The Lincoln National Life Insurance Company

4. The exception for non-medical leaves of absence in item (3) of the second paragraph may range from 2 weeks to 60 months, or may be omitted.
 5. the provision may be omitted if retiree coverage is provided.
- B. The **ALTERNATE CARE OR REHABILITATE FACILITY** definition will be included in its entirety if Alternate Care benefits are provided.
- C. The **ANNUAL/OPEN ENROLLMENT PERIOD** may be included if requested by the Group Policyholder and agreed upon by an underwriter. The underlined duration may range from 30 to 91 days. The underlined reference to employees/members may include the appropriate descriptions of the eligible members of the group in which such an enrollment period may apply.
- D. **CHANGE IN FAMILY STATUS** includes the following variability.
1. The definition may be included or omitted, depending on whether the Group Policyholder's administrative practices allow such changes for an accident plan.
 2. Additional status changes may be added to match a group's administrative practices:
 - a. domestic partnership/civil union;
 - b. change in classification from part-time to full-time or full-time to part-time.In this event, the respective statement will be added to the end of the definition:

Change in Family Status also includes a domestic partnership/civil union.

Change in Family Status also includes a change in classification from part-time to full-time or from full-time to part-time.
 3. References to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account/Plan/Fund or it may reference the name of the Group Policyholder's specific plan.
- E. The **CHIP FRACTURE** definition will be included in its entirety if this benefit is provided.
- F. The **CHILD CARE CENTER** definition will be included in its entirety if Family Care benefits are provided.
- G. The **COMA** definition will be included in its entirety if this benefit is provided.
- H. The **COMMON CARRIER** definition will be included in its entirety if benefits for Common Carrier Accident are provided.
- I. The **COMMON CARRIER ACCIDENT** definition will be included in its entirety if this benefit is provided.
- J. The **COMPANION** definition will be included in its entirety if Lodging benefits are provided.
- K. In the definition of **COMPANY**, we request variability for the underlined group insurance service office and its address.
- L. In the **DAY OR DATE** definition, the Group Policyholder or the Participating Organization may be shown.
- M. The **DENTIST** definition will be included in its entirety if Dental Injury benefits are provided.
- N. The **DEPENDENT ACCIDENT INSURANCE** definition will be included in its entirety if benefits are provided for dependents.
- O. The **DISLOCATION** definition will be included in its entirety if Dislocation benefits are provided.

The Lincoln National Life Insurance Company

- P. **ELIGIBILITY WAITING PERIOD** is to be filed as variable so the text prior to the slash can be included if the eligibility waiting periods are continuous; or, the text following the slash can be included if the eligibility waiting period is based on membership or a non-standard waiting period; the bracketed reference to Participating Organization may be included if the Group Policyholder has subsidiaries or affiliates to be covered; or the definition may be omitted in its entirety if no eligibility waiting period applies. Alternate version:
- ELIGIBILITY WAITING PERIOD** means the period of time that [an Employee/description of eligible members in which an eligibility waiting period applies] must be [in an eligible class with the Group Policyholder or Participating Organization/ a member in good standing with the Group Policyholder or Participating Organization], before he or she becomes eligible to enroll for coverage under this Policy.
- Q. The **EMERGENCY CARE FACILITY** definition will be included in its entirety if Emergency Care benefits are provided.
- R. **EMPLOYEE** is to be filed as variable so it can include Full-Time Employees, Full-Time Employees or Regular Part-Time Employees, or can be extended to other descriptions of the members to be included as denoted in the class descriptions provided by the Group Policyholder (Associate, Participant, Member, Owner, Partner, Retiree, etc.). If coverage is provided to a class of non-employees (i.e. union members, retirees) the definition may be omitted. If the Group Policyholder has subsidiaries or affiliates, "or Participating Organization" may be included in the sentence. If only Full-Time Employees are included, the definition of Employee may be omitted to avoid redundancy.
- S. **FAMILY OR MEDICAL LEAVE** may be omitted if the group is not subject to FMLA law or similar state law or if such a leave is not applicable to a particular class of insureds. We request the ability to re-word this definition to reflect any change to federal requirements. The reference to Participating Organization may be included or omitted, as applicable, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.
- T. The **FRACTURE** definition will be included in its entirety if Fracture benefits are provided.
- U. In the definition of **FULL-TIME EMPLOYEE** the following variability applies.
1. Clarification may be added to specify if a Partner or Owner or specific type of professional is also to be included.
 2. Reference to Participating Organization may be included, if applicable, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.
 3. The minimum hours may be reflected in the definition in lieu of the Schedule of Benefits and may range from 10 – 40 hours per week (or hours over some longer period, such as a union hour bank or teaching schedule may require). The "per week" may be changed to reflect some other basis as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be reflected as per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, semester or some other specified period as provided by the group policyholder.
 4. The temporary or seasonal employee item may also include contracted employees. The item may be omitted if the group does not employ such employees or may be omitted if such employees are to be covered for the group.
 5. The last item may be omitted if an employer has employees also working in a business location outside the United States.
 6. The definition may be omitted if eligibility is based on membership (such as a union group) or retirees are covered.
- V. The **HOME HEALTH CARE AGENCY** definition will be included in its entirety if Follow-Up Care benefits are provided.
- W. In the definition of **HOSPITAL**, the underlined reference to Joint Commission is filed as variable in the event the commission's name is changed. If the definition is not needed, it will be omitted.

The Lincoln National Life Insurance Company

- X. The **HOSPITAL CONFINEMENT** definition will be included in its entirety if the Hospital Confinement benefits are provided.
- Y. The **INPATIENT** definition will be included in its entirety if Alternate Care and Rehabilitative Facility Confinement benefits are provided.
- Z. The underlined material in the definition of **INSURANCE MONTH** is variable so it may be changed if the insurance month falls on a date other than the 1st of the month. The bracketed reference to Group Policyholder/Participating Organization may reflect either or both. Example: (1) beginning at 12:01 a.m. on the 15th day of any calendar month; and (2) ending at 12:00 midnight on the 14th day of the next calendar month; at the Group Policyholder's primary place of business.
- AA. The **INSURED DEPENDENT** definition will be included in its entirety if benefits are provided for dependents.
- BB. The **INTENSIVE CARE UNIT (ICU)** definition will be included in its entirety if Intensive Care Unit (ICU) Confinement benefits are provided.
- CC. The **LOSS** definition will be included in its entirety if Dismemberment or Catastrophic Loss benefits are provided.
- DD. The **MEDICAL HEALTH PROFESSIONAL** definition will be included in its entirety if Follow-Up Care and Initial Physician Office Visit benefits are provided.
- EE. **MILITARY LEAVE** may be omitted if the group/class of insured is not subject to USERRA law or similar state law. We request the ability to re-word this definition to reflect any change to federal requirements. The reference to Participating Organization may be included or omitted, as applicable, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.
- FF. The **OBSERVATION UNIT** definition will be included in its entirety if Hospital Admission benefits are provided.
- GG. The **OCCUPATIONAL THERAPIST** definition will be included in its entirety if Follow-up Care benefits are provided.
- HH. The **OUTPATIENT TREATMENT** definition will be included in its entirety if Hospital Admission benefits are provided.
- II. **PAYROLL PERIOD** may be omitted when a group is not deducting contributions from its employees' payroll or if individual termination is not based on the end of the payroll period/cycle. The reference to Participating Organization may be included or omitted, as applicable, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.
- JJ. The **PERSON** definition is variable so it may reference the applicable eligible members as described by the Group Policyholder and reflected in the Class Descriptions, such as: Full-Time Employee, Regular Part-Time Employee, Active Member, Active Employee, Elected Official, Owner, etc. Item (2) may be omitted for noncontributory or takeover plans where enrollment is automatic.
- KK. The **PHYSICAL THERAPIST** definition will be included in its entirety if Follow-Up Care benefits are provided.
- LL. **REGULAR PART-TIME EMPLOYEE** definition is variable as described below.
 - 1. The definition may be included if part-time employees are to included.
 - 2. Clarification may be added to properly describe such employees.
 - 3. The applicable minimum hour requirement may be reflected in the definition in lieu of the Schedule of Benefits and the per week may be changed if based on some other basis, as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, or other specified period as provided by the group policyholder.

The Lincoln National Life Insurance Company

4. The temporary or seasonal employee item may also include contracted employees. The item may be omitted if the group does not employ such employees or may be omitted if the such employees are to be covered for the group.
5. The last item may be omitted if an employer has employees also working in a business location outside the United States.
6. The definition may be omitted if eligibility is based on membership (such as a union class) or if retirees are covered.

MM. The **RETIREE** definition may be added if retiree coverage is to be provided. **Retiree** definition is variable, so that case-specific information can be substituted. Examples ("Early" or "Normal" may be used in describing the type of Retiree; underlined variable numbers are hypothetical):

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who is eligible for retirement benefits.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) is [over the age of 65/ at least age 65/ has attained age 65]; and
- (2) has completed 10 or more years of service with the Group Policyholder/Participating Organization.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) has attained age 65;
- (2) has completed 10 or more years of service with the Group Policyholder/Participating Organization; and
- (3) has retired on or after [specific date provided by Group Policyholder].

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who has

- (1) 10 years of seniority with the Group Policyholder/Participating Organization as of [specific date provided by Group Policyholder];
- (2) reached age 65; and
- (3) retired without prejudice.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization:

- (1) who has attained age 65; or
- (2) whose employment has ceased due to retirement by the Group Policyholder/Participating Organization; and
- (3) who was insured under the Policy immediately prior to retirement.

[EARLY] RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who retired early under the Group Policyholder's/Participating Organization's retirement plan at age 55 through age 60 with at least 10 years of continuous service.

[NORMAL] RETIREE means a former employee of the Group Policyholder/Participating Organization who:

- (1) retired under the Group Policyholder's/Participating Organization's retirement plan on or after attaining 65 years of age; and
- (2) has incurred 10 or more years of creditable service with the Group Policyholder/Participating Organization; or
- (3) has incurred 10 years of service (this can include credit for military service) with the Group Policyholder/Participating Organization.

[EARLY] RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) took early retirement prior to attaining age 60; and
- (2) has incurred 10 or more years of creditable service with the Group Policyholder/Participating Organization.

The Lincoln National Life Insurance Company

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) has completed 10 or more years of service prior to retirement; and
- (2) is eligible to receive benefits under the school board's retirement plan.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) retired under the early or normal (age 65 with 10 years of credited service) retirement provisions of the Group Policyholder's/Participating Organization's retirement plan; or
- (2) retired on or after age 65 with less than 10 years of credited service, provided employment with the Group Policyholder/Participating Organization commenced prior to age 60.

RETIRED MEMBER means a Person who qualifies for a pension under [description provided by Group Policyholder].

RETIREE (see the Participating Organization/Group Policyholder for this information).

NN. In the certificate version, the bracketed reference to Employee/member in the definition of **YOU and YOUR** may reference the appropriate descriptions of the members eligible for coverage.

V. **GENERAL PROVISIONS.** Form GL41-5-GP includes the General Provisions of the Policy and GL42-5-GP includes the General Provisions applicable to the Certificate. GL41-5.1-PE is used when the Group Policyholder has Participating Organizations that are to be covered under the Policy. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. GL41-5-GP includes the following variability.

1. In the **ENTIRE CONTRACT** section, item (3) may be omitted if not applicable.
2. In the **INFORMATION TO BE FURNISHED** section, the bracketed reference to Participating Organization may be omitted if not applicable and the underlined period in which adjustments may be made may range from 12 to 60 months.
1. In the **ACTS OF THE POLICYHOLDER** section, the bracketed reference to employees/members may reflect the appropriate description of the members of the group.
4. In the **CERTIFICATES** section, the underlined reference to Group Policyholder/Participating Organization may reflect either the Group Policyholder or Participating Organization.

B. In the certificate form GL42-5-GP, item (3) of the **ENTIRE CONTRACT** section may be omitted if not applicable.

C. Group policy form GL41-5.1-PE, **PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS**, is to be used when a group policyholder has an affiliate or subsidiary to be insured under the policy or if more than one union or professional association or a combination are participating under the policy. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. We request the following variability.

1. In the first sentence of the form, the bracketed "employees or members" may reflect the appropriate description of the members of the group.
2. Under the definition of the **PARTICIPATING ORGANIZATION**, the bracketed list of Participating Organizations is to be filed as variable to list the actual names of those organizations to be included under the Policy.
4. Under the **EFFECTIVE DATE** section, the underlined "the first day of the Insurance Month following" may be reworded to reflect the appropriate date (the date of, the next day following, the first day of the Insurance Month coinciding with or next following, or other specified date).
5. Under the section entitled **TERMINATION**, the underlined dates under this section are variable so that coverage may end on the date, the next day following, the last day of the Insurance Month following, the last day of the payroll cycle/pay period, or on a specified day following the events listed.

The Lincoln National Life Insurance Company

VI. ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE. Forms GL41-6-ELE and GL42-6-ELE contain the Eligibility and Effective Date provisions for the individual group member.

We request that any reference to Group Policyholder or Participating Organization throughout the forms may reflect one or both terms, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.

The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. The **ELIGIBILITY** section includes the following variability.

1. In the first sentence, if only two items apply, the bracketed "latest of" may be changed to "later of" and the applicable punctuation will be reflected. If only one item remains, the "latest of" will be omitted.
2. Item (2) includes the following variability.
 - a. The item may be included if there are Participating Organizations included. The appropriate punctuation for the items included will be reflected.
 - b. The underlined date is to be filed as variable so a person may become eligible on the day, day following, first of month following, or any other specified day following the events listed.
3. Item (3) includes the following variability.
 - a. The underlined date is to be filed as variable so a person may become eligible on the day, day following, first of month following, or any other specified day following the events listed.
 - b. Item (3) may be omitted in its entirety if there is no Eligibility Waiting Period to be satisfied. The appropriate punctuation for the items remaining will be reflected.
4. In the bracketed **Prior Service Credit Towards Waiting Period**, if included, the following variability applies.
 - a. The bracketed reference to former employee/member may include the appropriate description of the members eligible for the credit.
 - b. The underlined duration in item (1) may range from 30 days to 2 years, if agreed upon by an underwriter.
 - c. Item (2) may be omitted if the group/class of insureds is not subject to FMLA or similar state requirement.
 - d. Item (3) may be omitted if the group/class of insureds is not subject to USERRA.
 - e. The section may be omitted if an Eligibility Waiting Period is not applicable or alternate language may be included to accommodate a group's administrative handling. Example:

"Prior Service in an ineligible class will apply toward the Waiting Period when:

- (1) an employee's employment status with the [Group Policyholder/Participating Organization] changes; and
- (2) such employee becomes a member of an eligible class."

"If a person is working as an ineligible Employee for the [Group Policyholder/Participating Organization] and then becomes a regular [Full-time] Employee of the Group Policyholder/Participating Organization], any time incurred with the [Group Policyholder/Participating Organization] as an ineligible Employee will be applied toward the Waiting Period." The bracketed "Full-Time" may be omitted.

"Prior Service with XYZ Company will apply toward the Waiting Period." This would be used when employees are transferring from one division or subsidiary to another or to the policyholder or in the event the policyholder purchases a company and wants a smooth transition for those employees transferring to the policyholder's plan of benefits.

The Lincoln National Life Insurance Company

- B. The bracketed **ENROLLMENT** section includes the following variability.
1. This section may be included when one or more of the items listed are applicable.
 2. Item (2) may be included if an Annual Enrollment Period or an Open Enrollment Period are included.
 3. In item (2) of this section, the underlined "Annual" may be changed to "Open" if an Open Enrollment Period is permitted in lieu of an Annual Enrollment Period.
 4. Item (3) of this section may be omitted if the Group Policyholder does not allow status changes. If included, the underlined 31 days may range from 30 to 91 days.
- C. Under the **EFFECTIVE DATE** section, the following variability applies.
1. The underlined dates are to be filed as variable throughout this section, so coverage can begin on the day, day following, first day of the Coverage Month/calendar coinciding with or next following, first day of the month following, or any other specified day following the events listed.
 2. In item (2), the Active Work rule can be omitted, or the following "Non-confinement" or "Period of Limited Activity" language can be added or substituted for non-employee classes (retirees, union members, etc.)
 - (2) the date the Person resumes Active Work, if not Actively at Work on the day his or her insurance would otherwise take effect;
 - (2) the day after the Person's final discharge from a hospital or other health care facility, if [the Person/a retiree] is confined to such a facility on the date he or she would otherwise become eligible; and
 - (2) the day after the Person's resumption of the normal activities of a healthy person of the same age and sex, if [the Person/a retiree] is in a Period of Limited Activity and unable to perform such activities the date he or she would otherwise become eligible; and
 3. In Item (3), the following variability applies.
 - a. The item may be omitted in its entirety if the coverage is non-contributory.
 - b. The bracketed "and signs" may be omitted along with items (a) or (b) or both (a) and (b) may be omitted if the group does not have any payroll deductions or Section 125 Plan.
 - c. The underlined Section 125 Plan may reference the appropriate plan for the group: Flexible Benefit Plan, Cafeteria Plan, Flexible Spending Account/Plan/Fund, or the specific name of the group's plan.
 4. The second paragraph regarding increases may be omitted if the group does not permit any increases to coverage. The active work language may be omitted or changed to the non-confinement period or period of limited activity language shown below for non-employee classes (retirees, union members, etc.):

Any increase in coverage or benefits becomes effective at 12:01 a.m. on the latest of:

 - (1) the day after the Person's final discharge from a hospital or other health care facility, if he or she is confined to such a facility on the date the increase would otherwise take effect; or
 - (2) the day after the Person's resumption of the normal activities of a healthy person of the same age and sex, if he or she is in a Period of Limited Activity and unable to perform such activities on the date the increase would otherwise take effect; and
 5. The last paragraph regarding decreases may be omitted if not applicable to the group. The active work language may be omitted for non-employee classes (retirees, union members, etc.):

Any reduction in coverage or benefits will take effect on the day of the change.
- D. The bracketed **ANNUAL/OPEN ENROLLMENT PERIOD** may be omitted in its entirety if neither an annual nor an open enrollment period is applicable to the group. The underlined "Annual/Open" may be changed to reflect one or the other as applicable.

The Lincoln National Life Insurance Company

- E. The **REINSTATEMENT RIGHTS** section may be omitted in its entirety if not applicable to the group or the class of eligible members covered (i.e. retirees, members, or no Eligibility Waiting Period to waive). If included, one or more periods may be waived, as applicable to the group. Reinstatement may be permitted upon return to work within 1 to 60 months, if enrolled within 31 to 91 days, or for other events to coincide with a group's administrative handling of various types of leaves. If included, the following variability applies.
1. The bracketed reference to reductions in hours may be included if requested by a group policyholder and agreed upon by an underwriter.
 2. The bracketed reference to Group Policyholder/Participating Organization throughout this section may show either or both, as applicable.
 3. Item (1) may be omitted if the group is not subject to FMLA law or similar state law in which coverage would be required to be reinstated.
 4. Item (2) may be omitted if the group/class is not subject USERRA.
 5. Items (3), (4), or (5) can be omitted or show different time periods to agree with the group's leave practices or union contracts. The time period may range from one month to 60 months or some other duration as agreed upon by an underwriter.
 6. Item (6) may be included if reinstatement is permitted when a person meets the minimum hours to return to an eligible class.
 7. The events listed may be expanded to include additional reinstatements due to a return to eligible status, sabbatical leaves, or other types of leaves to coincide with a group's administrative practices. In this event, the additional types of leaves and the applicable duration may be listed showing the specific description of the type of leave, sabbatical, or ineligible status and the duration subject to the same variability as indicated above.
 8. In the second paragraph, the following variability applies.
 - a. The underlined re-enrollment period can range from 31 to 91 days, to agree with the group's enrollment practices.
 - b. The underlined Active Work may be changed to reflect active status (as for a member).
 - c. The bracketed text in the first sentence of this paragraph may be included when the group policyholder or participating organization pay for the entire cost of the premium.

VII. TERMINATION OF PERSONAL ACCIDENT INSURANCE. Forms GL41-7-TE and GL42-7-TE contain the Individual Termination provisions for Personal Accident Insurance. Any reference to Group Policyholder or Participating Organization throughout the forms may reflect one or both terms, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

- A. Under the **TERMINATION** section, the underlined terms "day" or "date" are variable throughout, so that coverage may end on the day, the day following, the last day of the month following, last day of the payroll cycle/pay period, or any other specified day following the events listed. Variability is requested to support non-standard handling due to policyholders' administrative guidelines regarding terminations.
1. In Items (1) & (8), the references to Participating Organizations may be omitted when not applicable.
 2. Item (2) may be omitted at the policyholder's request if only one class is included under the Policy.
 3. In Items (3) and (8), language can be added or substituted to handle non-employee classes (retirees, union members, etc.).
Examples:
 - (3) the date such Insured Person ceases to be in a class which is eligible for coverage under this Policy or dies;
 - (3) the date such Insured Person ceases to be in a class which is eligible for coverage under this Policy, attains age [70 - 100], or dies;
 - (3) the date the Insured Person ceases to be an member with the [Group Policyholder/Participating Organization];
 - (8) the date the Insured Person's membership with the [Group Policyholder/Participating Organization] terminates;

The Lincoln National Life Insurance Company

4. At the policyholder's request, Item (5) may be omitted and Item (8) reworded to coincide with the group's billing cycle or administrative handling of terminations. Example:
 - (8) (a) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminates, if employment terminates on or before the 15th of the month;
 - (b) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminated if employment terminates after the 15th of the month;
 5. At the policyholder's request, Item (6) may be reworded to coincide with a policyholder's payroll cycle:
 - (6) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminates, or the last day of the payroll period for which premium payment is made on the Insured Person's behalf (whichever is later);
 6. At the policyholder's request Item (8) may be reworded for layoff situations:
 - (8) (a) if termination is due to a layoff, the last day of the Insurance Month which follows the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates;
 - (b) if termination is due to other than a layoff, the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates;
 7. Item (8) may also be reworded or split for specific classes to accommodate a group's administrative handling with respect to termination of employment, elected position, membership.
 8. At the policyholder's request, an item may be added to address coverage ending upon retirement:
the day after the Insured Person retires with the Group Policyholder or Participating Organization;
 9. At the policyholder's request, an item may be added to address the exhaustion of paid time off or vacation time upon termination:
the day after any paid time off (PTO) and/or vacation time is exhausted due to termination of the Insured Person's employment with the Group Policyholder or Participating Organization;
 10. In Item (9), military service of 30 days to 5 years may be exempted or the item may be omitted.
- B. The **CONTINUATION RIGHTS** section may be included or it may be omitted if it not applicable to the particular group (i.e. retirees, members). The continuations may be included or omitted as applicable to the particular class of insureds (i.e. retirees, members). If applicable to certain classes, a phrase may be added before the particular continuation to denote the class in which the continuation applies. If included, the following variability applies.
1. Throughout this section, references to Group Policyholder/Participating Organization may include one or both terms; or we may name a specific employer, subsidiary, affiliate or affiliates to which the provision applies.
 2. The bracketed reference to the reduction in hours in the first paragraph may be omitted if such continuation is not applicable.
 3. In the **Disability** section, the following variability applies.
 - a. Item (1) of the first paragraph may be included or omitted. The underlined duration of the continuation may range from the end of the month or up to 24 months or some other specified period to accommodate a group's administrative guidelines or union contracts.

The Lincoln National Life Insurance Company

- b. The bracketed second paragraph may be included if premiums are to be waived. If included:
 - i. the underlined timeframe in the first line may be added with a range of 1 to 90 days; and
 - ii. the underlined time frames in items (1) and (2) of the second paragraph are variable to denote the time period in which the waiver applies and may reflect the specified duration or date or number of days the waiver is applicable. In no event will waiver extend beyond a period in which the person is no longer disabled.
4. The **Family or Medical Leave** and the **Military Leave** sections can be omitted for groups not subject to these federal laws or any similar state laws or if such leaves are not applicable to the class of eligible members covered. We request the ability to re-word these provisions to reflect any change to federal requirements.
5. The **Lay-Off Or Leave Of Absence** section includes the following variability.
 - a. The Lay-Off or Leave of Absence continuation may be omitted when the group does not allow continuation during such absences or if such absences are not applicable to the type of eligible members covered.
 - b. The underlined duration may range from the end of the month in which the leave began to 60 Insurance/ calendar months. For example, if the continuation is for one month, the last sentence may read: "The required premium payment must be received from the Group Policyholder. If the continuation period is longer than one month, the last sentence will read: "The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage."
 - c. If the duration is different between lay-off and leave of absence, this section may be divided to reflect the continuation period specific to the type of absence or show one or the other if either is not applicable:
6. In the **Temporary Reduction in Hours** section, if included, the underlined duration may range from the end of the month in which the reduction occurred to 24 months.
7. In the **Conditions** section, the last sentence may be omitted if a union agreement requires coverage or with underwriter approval.
8. Additional continuation periods may be added (as may be required by federal or local law, the group's compensation program or union agreements, a prior carrier's contract, etc.). Examples (the underlined durations typically range from one month to three months but may be extended up to 24 months):
 - a. **Sabbatical Leave.** If [an Insured Person/you] cease(s) work due to an approved sabbatical, coverage may be continued [for three Insurance Months after the sabbatical begins or until the end of an approved sabbatical]. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
 - b. **Plant Closing or Mass Lay Off.** If [an Insured Person is/ you are] not provided a 60-day notice by the Group Policyholder/Participating Organization of a plant closing or of a mass lay off and [the Insured Person/you] cease(s) work due to a lay off as a result of a plant closing or of a mass lay off, then coverage may be continued:
 - (1) for up to 60 days after the lay off begins;
 - (2) provided premium payments are made on [the Insured Person's/your] behalf.

The Lincoln National Life Insurance Company

- c. **Lay Off (other than due to a Plant Closing or Mass Lay Off) or Other Leave.** If [an Insured Person/you] cease(s) work due to a temporary lay off (not as a result of a plant closing or of a mass lay off), or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
- d. **Coverage Continuation Agreements.** If [an Insured Person is/you are] severed from employment, retire, or terminate employment, then coverage may be continued until the end of [the Insured Person's/your] contract period in accord with any severance agreement, consulting agreement, or union agreement. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
- e. **Severance.** If [an Insured Person's/your] position with the Group Policyholder/Participating Organization is eliminated, then coverage may be continued for three Insurance Months following the date employment terminated [based upon the Insured Person's/your length of service and position with the Group Policyholder/Participating Organization]. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.

C. In the **PORTABILITY** section, the underlined 31 days may range from 30 to 91 days.

VIII. ELIGIBILITY FOR DEPENDENT ACCIDENT COVERAGE. Policy form GL41-8-ELD AR and GL42-8-ELD AR contain the definitions, eligibility, and effective dates for Dependents. We request the following to be filed as variable.

- A. In the **DEPENDENT** section, the following variability applies.
 - 1. In Item (2) of the first paragraph:
 - a. the underlined ages in item (2) are filed as variable so that they may be increased but not decreased (19 – 30); and
 - b. "regardless of student status" may be included at the end of item (2) if dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines.
 - 2. Item (3) of the first paragraph:
 - a. may be omitted if the dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines; or
 - b. the underlined ages may be increased (19-30).
 - 3. In item (4) of the first paragraph:
 - a. the underlined age may be increased (19–30); and
 - b. the underlined timeframe for providing proof may range from 31 to 91 days.
 - 4. The bracketed text at the end of the first paragraph regarding a QMCSO may be omitted if not applicable.

The Lincoln National Life Insurance Company

- B. The **ELIGIBILITY** section includes the following variability.
1. In the first paragraph of this section, the underlined dates are variable so they can be the day, the next day of the Coverage Month, the first day of the Coverage Month, or other specified date following the events listed.
 2. The second paragraph of the **ELIGIBILITY** section may be omitted in its entirety if there is no Change in Family Status or Annual or Open Enrollment Period included. If it is included, the following variability applies.
 - a. Either or both of items (1) and (2) may be included.
 - b. The underlined enrollment period in item (1) may range from 30 to 91 days.
 - c. The underlined "Annual/Open" in item (2) of the second paragraph of this section may reflect either "Annual" or "Open" for the type of enrollment applicable.
 3. In the third paragraph of this section, the last sentence may be omitted.
- C. **ANNUAL/OPEN ENROLLMENT PERIOD** may be included if the group has an Annual or Open Enrollment Period. The underlined "Annual/Open" may reflect either "Annual" or "Open" for the type of enrollment applicable.
- D. Under the **EFFECTIVE DATES FOR DEPENDENT DENTAL COVERAGE**, the following variability applies.
1. The underlined dates may be the day, the day following, first of the Insurance Month following, or any other specified day following the events listed.
 2. In item (2), the bracketed language regarding additional premium may be omitted if additional premium is not required or if the group policyholder does not do payroll deduction or has a Section 125 plan, or similar plan. If applicable, the underlined Section 125 may specify the particular plan applicable to the group: Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account/Plan/Fund or it may name the group policyholder's specific plan. (a) or (b) may be included or omitted as applicable to the group.
- E. Under the **NEW DEPENDENTS** section, the following variability applies.
1. In item (2), if the group does not have payroll deduction or the group does not have a Section 125 Plan or similar plan, either or both of these references may be omitted.
 2. The underlined reference to Section 125 Plan (Cafeteria Plan, Flexible Spending Account, specific name of group's plan) may specify the applicable plan to the group or be omitted.
 3. The underlined timeframe may range from 30 to 91 days.

IX. TERMINATION OF DEPENDENT ACCIDENT INSURANCE. GL41-9-TD and certificate form GL42-9-TD contain the termination provisions for Dependents. We request the following to be filed as variable.

- A. In the **TERMINATION** section, the underlined dates are variable so coverage can end on the day, the last day of the Insurance Month, or other specified date following the events listed.
- B. Under the **SURVIVING DEPENDENTS** section, the following variability applies.
1. The underlined duration of item (1) may be changed with a range of 1 to 60 months.
 2. The **Surviving Dependents** paragraph may be omitted in its entirety.
- C. The **REINSTATEMENT OF COVERAGE** section may be omitted in its entirety if reinstatement of coverage is not applicable to the group/class.

The Lincoln National Life Insurance Company

- X. PREMIUMS AND PREMIUM RATES.** Form GL41-10-PR includes the Premium provisions, a Grace Period provision, and a Premium Rates Schedule. We request variable filing of the following underlined or bracketed material.
- A. We request the bracketed references to Group Policyholder/Participating Organization to be variable throughout this form so either or both may be included as applicable to the group.
 - B. In the **GRACE PERIOD** section, the underlined period is to be filed as variable so it may range from 31 to 91 days.
 - C. Under the **PAYMENT RATE CHANGE** section, the following variability applies.
 - 1. The underlined "first" in reference to the anniversary may be changed to reflect the appropriate applicable anniversary in which the rates will change (first, second, third).
 - 2. In the last sentence of this section, the underlined notice period for a rate-up may range from 31 days to 180 days.
 - D. In the **PREMIUM AMOUNT** section, the bracketed text following item (2) may be omitted when a billing fee is not included. Billing fees may be applied depending upon the billing mode requested by the Group Policyholder. In the final paragraph of this section, the effective date can be the first day of the Insurance month or any other specified date.
 - E. The bracketed **PREMIUM RATE SCHEDULE** is to be filed as variable so that the applicable coverages and rates are reflected for the specific group.
- XI. POLICY TERMINATION.** Policy form GL41-11-PT includes Policy Termination provisions.
- A. We request the bracketed references to Participating Organization to be variable throughout this form so Participating Organization may be included or omitted as applicable to the group.
 - B. In the **TERMINATION BY THE COMPANY** section, the underlined notice period may range from 31 to 180 days.
 - C. Under the **TERMINATION BY GROUP POLICYHOLDER** section, the underlined date may be changed to be the day following, the last day following, the last day of the Insurance Month, quarter, etc. to coincide with the billing mode for the group, or other specified day.

The Lincoln National Life Insurance Company

XII. EMERGENCY CARE BENEFITS. Forms GL41-12-ECB and GL42-12-ECB describe the emergency care benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. The benefits may include one or more of the following: Ambulance Transportation, Air Ambulance Transportation, Emergency Care Treatment, Initial Physician Office Visit, Major Diagnostic Exam. Any one bracketed benefit may be included or omitted in its entirety. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. The following variability applies if such benefits are to be included. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. AMBULANCE TRANSPORTATION.

1. The underlined 90 days may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

B. AIR AMBULANCE TRANSPORTATION.

1. The underlined 48 or 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

C. EMERGENCY CARE TREATMENT.

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

D. INITIAL PHYSICIAN OFFICE VISIT.

1. The underlined 60 days may range from 30 to 90 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

E. MAJOR DIAGNOSTIC EXAM.

1. The underlined 60 days may range from 30 to 90 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

XIII. TREATMENT CARE BENEFITS. Forms GL41-13-TCB and GL42-13-TCB describe the treatment care benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. The benefits may include one or more of the following: Hospital Admission, Hospital Confinement, Intensive Care Unit (ICU) Confinement, Alternate Care and Rehabilitative Facility Confinement, Follow-Up Care, Transportation, Lodging, Family Care. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. Any one bracketed benefit may be included or omitted in its entirety. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. The following variability applies if such benefits are to be included.

A. HOSPITAL ADMISSION.

1. The underlined 180 days may range from 90 to 365 days.
2. The underlined 20 hours may range from 18 to 23 hours.
3. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

B. HOSPITAL CONFINEMENT.

1. The underlined 180 days may range from 90 to 365 days.
2. The underlined 365 days may range from 90 days to two years.
3. The underlined two-year period may range from one to three years.

C. INTENSIVE CARE UNIT (ICU) CONFINEMENT.

1. The underlined 30 days may range from 15 to 60 days.
2. The underlined 15 days may range from 5 to 30 days.
3. The underlined two-year period may range from one to three years.

The Lincoln National Life Insurance Company

D. **ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT.**

1. The underlined 180 days may range from 90 to 365 days.
2. The underlined 90 days may range from 60 to 365 days.
3. The underlined two-year period may range from one to three years.

E. **FOLLOW-UP CARE.**

1. The underlined 365 days may range from 90 days to two years.
2. The underlined 6 times may range from 1 to 15 (6 is the standard).

F. **TRANSPORTATION.**

1. The underlined 100 miles may range from 50 to 150 miles.
2. The underlined "up to three times" may range from once to 5 times. If once, "up to three times" will be replaced with "once."

G. **LODGING.**

1. The underlined 100 miles may range from 50 to 150 miles.
2. The underlined 30 days may range from 15 to 60 days.
3. The underlined 365 days may range from 90 days to two years.

H. **FAMILY CARE.**

1. The underlined 30 days may range from 15 to 60 days.
2. The underlined 365 days may range from 90 days to two years.

XIV. SPECIFIC INJURIES OR TREATMENTS. Forms GL41-14-SIT and GL42-14-SIT describe the specific injuries or treatments benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. The benefits may include one or more of the following: Fracture; Dislocation; Blood, Plasma, Platelets; Burns; Skin Graft; Coma; Concussion; Dental Injury; Eye Injury; Joint Replacement; Laceration, Knee Cartilage; Tendon/Ligament/Rotator Cuff; Ruptured Disc; Surgery (Abdominal or Thoracic); Surgery (Arthroscopic). Any one bracketed benefit may be included or omitted in its entirety. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. The following variability applies if such benefits are to be included.

A. **FRACTURE.** The underlined 90 days may range from 60 to 365 days.

B. **DISLOCATION.** The underlined 90 days may range from 60 to 365 days.

C. **BLOOD, PLASMA, PLATELETS.**

1. The underlined 90 days may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

D. **BURNS.**

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

E. **SKIN GRAFT.** The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

F. **COMA.**

1. The underlined 15 or more may range from 5 to 30 days. The "or more" may be included or omitted.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

G. **CONCUSSION.**

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

The Lincoln National Life Insurance Company

H. **DENTAL INJURY.**

1. The underlined 7 days may range from the first day to 15 days.
2. The underlined "one" may range from one to three.

I. **EYE INJURY.**

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

J. **JOINT REPLACEMENT.**

1. The underlined 90 may range from 60 to 365 days.
2. The underlined "one" may be changed to two. If two, hip, knee, and shoulder will be pluralized, as applicable.

K. **LACERATION.**

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."
3. The underlined "one" may be changed to "two." If two, Covered Accident will be pluralized.

L. **KNEE CARTILAGE.**

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

M. **TENDON/LIGAMENT/ROTATOR CUFF.**

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

N. **RUPTURED DISC.**

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

O. **SURGERY (ABDOMINAL OR THORACIC).**

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

P. **SURGERY (ARTHROSCOPIC).**

1. The underlined 72 hours may range from 24 to 96 hours.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

XV. TRANSITIONAL CARE BENEFITS. Forms GL41-15-TRNCB and GL42-15-TRNCB describe the transitional care benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. The benefits may include one or more of the following: Medical Appliance Assistance, Prosthesis, Reasonable Modifications. Any one bracketed benefit may be included or omitted in its entirety. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. The following variability applies if such benefits are to be included.

A. **MEDICAL APPLIANCE ASSISTANCE.**

1. The underlined 365 days may range from 90 days to two years.
2. The underlined two-year period may range from one to three years.
3. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."
4. The under "one" may range from 1 to 3 times.

The Lincoln National Life Insurance Company

B. PROSTHESIS.

1. The underlined 365 days may range from 90 days to two years.
2. The underlined two-year period may range from one to three years.
3. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

C. REASONABLE MODIFICATIONS.

1. The underlined two-year period may range from one to three years.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

XVI. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS. Forms GL41-16-ADD and GL42-16-ADD describe the AD&D benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. In addition to the AD&D benefits, one or more of the following benefits may also be included: Common Carrier Accident, Transportation of Remains, Seat Belt/Helmet, Common Disaster, Catastrophic Loss. Any one bracketed benefit may be included or omitted in its entirety. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. The following variability applies if AD&D and any of the additional benefits are to be included.

A. ACCIDENTAL DEATH OR DISMEMBERMENT. The underlined 365 days may range from 90 days to two years.

B. COMMON CARRIER ACCIDENT.

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

D. TRANSPORTATION OF REMAINS.

1. The underlined 100 miles in the first sentence may range from 50 to 150 miles.
2. The underlined 30 miles in item (2) may range from 20 to 50 miles.
3. The underlined "one" may range from one to three. If more than "one," "benefit" will be pluralized in the last sentence of the first paragraph.

E. SEAT BELT/HELMET. No variability contained in this benefit other than it may be omitted in its entirety.

F. COMMON DISASTER. The underlined 365 days may range from 90 days to two years.

G. CATASTROPHIC LOSS.

1. The underlined 365 days may range from 90 days to two years.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

XVII. ACCIDENTAL DISMEMBERMENT BENEFITS. Forms GL41-16-DSMBR and GL42-16-DSMBR may be included in lieu of the AD&D forms if a group does not want to include the Accidental Death benefit. These forms describe the Accidental Dismemberment benefits that may be payable as the result of Injuries sustained in a Covered Accident. The bracketed plan/class may be included to describe the appropriate plan/class to which the benefits apply. In addition to the Accidental Dismemberment benefits, one or more of the following benefits may also be included: Common Carrier Accident, Seat Belt/Helmet, Catastrophic Loss. Any one bracketed benefit may be included or omitted in its entirety. The bracketed "one or more of" and "s" after "benefits" may be omitted if only one benefit is included. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. The following variability applies if Accidental Dismemberment and any of the additional benefits are to be included.

A. ACCIDENTAL DISMEMBERMENT. The underlined 365 days may range from 90 days to two years.

B. COMMON CARRIER ACCIDENT.

1. The underlined 90 may range from 60 to 365 days.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

C. SEAT BELT/HELMET. No variability contained in this benefit other than it may be omitted in its entirety.

The Lincoln National Life Insurance Company

D. **CATASTROPHIC LOSS.**

1. The underlined 365 days may range from 90 days to two years.
2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

XVIII. LIMITATIONS and EXCLUSIONS. Forms GL41-17-EX AR and GL42-17-EX AR list the limitations and exclusions. The bracketed plan/class in the header may be included to describe the appropriate plan/class to which the limitations apply. In item (7), the bracketed text may be included if business travel is to be excepted; if included. The underlined Group Policyholder or Participating Organization may include both or either one or the other. The text pertaining to the Group Policyholder's or Participating Organization's aircraft can be changed to include chartered flight, leased aircraft, or operated or controlled aircraft. In item (8), the blood alcohol level may range from .08 to .10. Item (9) may be deleted in its entirety if 24-hour coverage is provided; if omitted, the remaining items will be numbered accordingly. In item (15) the underlined jurisdictions may be included or omitted or other countries may be added and the underlined duration may range from 3 months to two years.

XIX. BENEFICIARY. Forms GL41-18-B and GL42-18-B include the Beneficiary provisions. If there are no death benefits to be included, these forms may be omitted from include in the policy and certificate. The following variability applies.

A. **PAYMENTS TO BENEFICIARY.**

1. Either the first or second bracketed **PAYMENTS TO BENEFICIARY** text will be included. The first bracketed **PAYMENTS TO BENEFICIARY** text, which is the traditional beneficiary provision, may be included if payments are to be made to the estate when no beneficiary is named or survives. The second bracketed **PAYMENTS TO BENEFITS** text, which is the preferential beneficiary provisions and the standard provision, may be included if payments are to be made to the relatives listed when no beneficiary is named or survives.
2. In the second bracketed **PAYMENTS TO BENEFICIARY** text, the bracketed domestic partner or civil union partner may be included if requested by the group policyholder.
3. The fourth paragraph shown on the form will be included, regardless of which bracketed **PAYMENTS TO BENEFICIARY** text will be included. Within this fourth paragraph, the underlined 15 days, denoting the time between deaths of insured and beneficiary, may range from 1 to 15 days.

B. **CHANGING THE BENEFICIARY.** The underlined text may reflect where written notice of the change in beneficiary is to be sent.

C. **FACILITY OF PAYMENT.** The underlined facility of payment amount may range from \$250 to \$2,500.

XX. CLAIMS PROCEDURES. Group policy form GL41-19-CP and certificate form GL42-19-CP describe the Claims Procedures for Accident insurance benefits. These claims procedures incorporate both the state and federal requirements. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent; and the appropriate verb will be used to agree with the subject. We request variable filing of the following.

A. In the **Notice of Claim** under the **NOTICE AND PROOF OF CLAIM** section, the underlined "Company's Group Insurance Service Office" is to be filed as variable so that requests can be directed elsewhere when other claims processing arrangements have been made.

B. Within the **TO WHOM PAYABLE** section, the bracketed first paragraph will be included if accidental death benefits are provided. If Accidental Death benefits are not provided, the first paragraph will be omitted and "Other" will be removed from the second paragraph. If dependent coverage is not provided, (2) will be omitted and the punctuation will be adjusted accordingly.

C. The bracketed **Claims Subject to ERISA** paragraph is to be filed as an omit-only variable so it may be removed (but not reworded) for non-ERISA groups.

D. Under the **RIGHT OF RECOVERY** provision, the underlined time limit for reimbursement may be increased but not decreased with a range of 60 days to 90 days.

E. The bracketed **COMPANY'S DISCRETIONARY AUTHORITY** may be omitted in its entirety but not reworded.

The Lincoln National Life Insurance Company

- XXI. OFF THE JOB ACCIDENT DISABILITY BENEFIT.** Amendment forms GL41-AMEND.OTJADI and GL42-AMEND.OTJADI may be attached to the Accident insurance policy and certificate to provide a monthly Total Disability benefit if a person becomes Totally Disabled as a result of an off the job Injury sustained in a Covered Accident. The following variability applies.
- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
 - B. The bracketed references to a Dependent Spouse may be omitted throughout if the benefit provided by the amendment is not to be extended to include a Dependent Spouse; and the appropriate verb will be used to agree with the subject.
 - C. The bracketed first sentence under **OFF THE JOB ACCIDENT DISABILITY BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
 - D. The **SCHEDULE OF BENEFITS** is to be filed as variable to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields.
 - 1. Name of Insured to be included if the inclusion of the benefit is elected at the individual's level.
 - 2. Effective Date to reflect the Insured Person's effective date if the benefit is elected at the individual's level.
 - 3. Monthly Benefit Amount For Insured Person may range from \$400 to \$1,500.
 - 4. Monthly Benefit Amount For Insured Dependent Spouse may be omitted if Dependent Spouse coverage not included. If included, the amount may range from \$400 to \$1,500.
 - 5. Maximum Benefit Period may range from 3 to 18 months
 - 6. Elimination Period.
 - a. The bracketed period for Inpatient Hospitalization may be omitted. If included, the underlined days may range from 0 (None) to 30 days.
 - b. The underlined days may range from 0 (None) to 30 days.
 - E. **DISABILITY BENEFIT.**
 - 1. The underlined 90 days may range from 90 to 180 days.
 - 2. The underlined age may reflect a specific age (60 – 80) or reference SSNRA.
 - F. **RECURRENT DISABILITY.** The underlined days in which the Recurrent Disability begins may range from 90 to 180 days.
 - G. The bracketed **WAIVER OF PREMIUM** section may be included or omitted in its entirety. If included, the following variability applies to item (1).
 - 1. The bracketed period in which a person may be Totally Disability may be omitted, if included, the period may range from 1 to 90 days.
 - 2. The bracketed reference to the Accident Policy and Amendment may indicate if the waiver is to apply to the Accident Insurance Policy or to this Policy/Certificate Amendment, or both the policy and amendment.
 - 3. The date in which the waiver may begin may coincide with the group's billing cycle or reflect some other specified date.
 - H. Under **DEFINITIONS**, the following variability applies.
 - 1. The bracketed definition of Insured Dependent Spouse may be omitted in its entirety if the amendment is not intended to extend coverage to a Dependent Spouse. If included, the bracketed domestic partner or civil union partner may be included if requested by the group policyholder.
 - 2. The bracketed Social Security Normal Retirement Age (SSNRA) chart will be included if Total Disability is to begin prior to attaining SSNRA.
 - I. In the **EXCLUSIONS**, the bracketed second sentence may be included when the Accident Insurance Policy to which the amendment is attached provides 24-hour coverage.

The Lincoln National Life Insurance Company

J. CLAIMS PROCEDURES.

1. In the **Notice of Claim** section, the underlined "Company's Group Insurance Service Office" is to be filed as variable so that requests can be directed elsewhere when other claims processing arrangements have been made.
2. Under the **Examination** section, the underlined "twice" in the third paragraph may range from 2 to 3 times and the bracketed "Good Cause" text may be omitted.
3. In the **To Whom Payable** section, the last sentence may be omitted if the benefit provided by the amendment is not extended to include a Dependent Spouse.
4. The bracketed **Claims Subject to ERISA** paragraph is to be filed as an omit-only variable so it may be removed (but not reworded) for non-ERISA groups.
5. Under the **Right of Recovery** section, the underlined time limit for reimbursement may be increased but not decreased with a range of 60 days to 90 days.
6. The bracketed **COMPANY'S DISCRETIONARY AUTHORITY** may be omitted in its entirety but not reworded.

XXII. SICKNESS AND OFF THE JOB ACCIDENT DISABILITY BENEFIT. Amendment forms GL41-AMEND.SAOTJADI and GL42-AMEND.SAOTJADI may be attached to the Accident insurance policy and certificate to provide a monthly Total Disability benefit if a person becomes Totally Disabled as a result of an off the job Injury sustained in a Covered Accident or a Sickness. The following variability applies.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to a Dependent Spouse may be omitted throughout if the benefit provided by the amendment is not to be extended to include a Dependent Spouse; and the appropriate verb will be used to agree with the subject.
- C. The bracketed first sentence under **SICKNESS AND OFF THE JOB ACCIDENT DISABILITY BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. The **SCHEDULE OF BENEFITS** is to be filed as variable to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields.
 1. Name of Insured to be included if the inclusion of the benefit is elected at the individual's level.
 2. Effective Date to reflect the Insured Person's effective date if the benefit is elected at the individual's level.
 3. Monthly Benefit Amount For Insured Person may range from \$400 to \$1,500.
 4. Monthly Benefit Amount For Insured Dependent Spouse may be omitted if Dependent Spouse coverage is not included. If included, the amount may range from \$400 to \$1,500.
 5. Maximum Benefit Period may range from 3 to 18 months
 6. Elimination Period.
 - a. The bracketed period for Inpatient Hospitalization may be omitted. If included, the underlined days may range from 0 (None) to 30 days.
 - b. The underlined days may range from 0 (None) to 30 days.
- E. **DISABILITY BENEFIT.**
 1. The underlined 90 days may range from 90 to 180 days.
 2. The underlined age may reflect a specific age (60 – 80) or reference SSNRA.
- F. **RECURRENT DISABILITY.** The underlined days in which the Recurrent Disability begins may range from 90 to 180 days.

The Lincoln National Life Insurance Company

- G. The bracketed **WAIVER OF PREMIUM** section may be included or omitted in its entirety. If included, the following variability applies to item (1).
1. The bracketed period in which a person may be Totally Disability may be omitted, if included, the period may range from 1 to 90 days.
 2. The bracketed reference to the Accident Policy and Amendment may indicate if the waiver is to apply to the Accident Insurance Policy or to this Policy/Certificate Amendment, or both the policy and amendment.
 3. The date in which the waiver may begin may coincide with the group's billing cycle or reflect some other specified date.
- H. Under **DEFINITIONS**, the following variability applies.
1. The bracketed definition of Insured Dependent Spouse may be omitted in its entirety if the amendment is not intended to extend coverage to a Dependent Spouse. If included, the bracketed domestic partner or civil union partner may be included if requested by the group policyholder.
 2. The bracketed Social Security Normal Retirement Age (SSNRA) chart will be included if Total Disability is to begin prior to attaining SSNRA.
- I. In the **EXCLUSIONS**, the bracketed second sentence may be included when the Accident Insurance Policy to which the amendment is attached provides 24-hour coverage.
- J. **CLAIMS PROCEDURES.**
1. In the **Notice of Claim** section, the underlined "Company's Group Insurance Service Office" is to be filed as variable so that requests can be directed elsewhere when other claims processing arrangements have been made.
 2. Under the **Examination** section, the underlined "twice" in the third paragraph may range from 2 to 3 times and the bracketed "Good Cause" text may be omitted.
 3. In the **To Whom Payable** section, the last sentence may be omitted if the benefit provided by the amendment is not extended to include a Dependent Spouse.
 4. The bracketed **Claims Subject to ERISA** paragraph is to be filed as an omit-only variable so it may be removed (but not reworded) for non-ERISA groups.
 5. Under the **Right of Recovery** section, the underlined time limit for reimbursement may be increased but not decreased with a range of 60 days to 90 days.
 6. The bracketed **COMPANY'S DISCRETIONARY AUTHORITY** may be omitted in its entirety but not reworded.

XXIII SICKNESS HOSPITAL CONFINEMENT BENEFIT. Amendment forms GL41-AMEND.SHCB and GL42-AMEND.SHCB may be attached to the Accident insurance policy and certificate to provide a daily hospital confinement benefit as a result of a Sickness. The following variability applies.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to a Dependent may be omitted throughout if the benefit provided by the amendment is not to be extended to include a Dependent.
- C. The bracketed first sentence under **SICKNESS HOSPITAL CONFINEMENT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. The **SCHEDULE OF BENEFITS** is to be filed as variable to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields.
1. Name of Insured to be included if the inclusion of the benefit is elected at the individual's level.
 2. Effective Date to reflect the Insured Person's effective date if the benefit is elected at the individual's level.
 3. Daily Hospital Confinement Benefit Amount For Insured Person may range from \$50 to \$500.
 4. Daily Hospital Confinement Benefit Amount For Insured Dependent may be omitted if Dependent coverage is not included. If included, the amount may range from \$50 to \$500.
 5. Maximum Benefit Period Per Confinement may range from 15 to 60 days.
- E. **HOSPITAL CONFINEMENT.** The underlined age may reflect a specific age (60 – 80) or reference SSNRA.

The Lincoln National Life Insurance Company

- F. **RECURRENT HOSPITAL CONFINEMENT.** The underlined days in which the Recurrent hospital Confinement begins may range from 90 to 180 days.
- G. Under **DEFINITIONS**, the bracketed Social Security Normal Retirement Age (SSNRA) chart will be included if Total Disability is to begin prior to attaining SSNRA.
- H. In the **EXCLUSIONS**, the last sentence may be omitted at the request of the group policyholder. If included, the underlined 5 days may range from 1 to 15 days.

XXIV. HEALTH ASSESSMENT BENEFIT. Amendment forms GL41-AMEND.HLTHA and GL42-AMEND.HLTHA may be attached to the Accident insurance policy and certificate to provide a health assessment benefit. The following variability applies.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to a Dependent may be omitted throughout if the benefit provided by the amendment is not to be extended to include a Dependent.
- C. The bracketed first sentence under **HEALTH ASSESSMENT BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. The **SCHEDULE OF BENEFITS** is to be filed as variable to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields.
 - 2. Name of Insured to be included if the inclusion of the benefit is elected at the individual's level.
 - 2. Effective Date to reflect the Insured Person's effective date if the benefit is elected at the individual's level.
 - 3. Health Assessment Period may show the beginning and end date. The assessment period may range from a six month to 24-month period.
 - 4. Health Assessment Benefit amount may range from \$10 - \$100 per test (\$50 as standard). The maximum number of tests to be payable in a given assessment period may range from 1 to 10. The bracketed text for Overall Maximums may be omitted if not included.
 - 5. Overall Maximum of Tests, if included, may range from 1-10. If the benefit provided by this amendment is extended to include Dependents, "per family" will be added.
 - 6. Overall Maximum Benefit Amount, if included, may range from \$100 to \$1,000. If the benefit provided by this amendment is extended to include Dependents, "per family" will be added.
- E. Under the **DEFINITION** section, the list of **Health Assessment Tests** is variable so items may be included or omitted. The last underlined item may be reworded to name additional tests that may become available as health assessment tests as recommended by the American Medical Association.

XXV. AMENDMENT (General Amendment). GL41-AMEND and GL42-AMEND are "open-faced amendments." They are for amending variable information after issuance. We request the bracketed body, underlined effective date, and officer signature to be filed as variable; and the bracketed "Accepted By" signature block to be file as drop-out variable so it may be omitted in those situations where a unilateral amendment is permissible.

XXVI. APPLICATION FORM. For **group application** GL2-APP.02/10, we request the following bracketed or underlined material to be variable.

- A. The term group insurance service office and its **address**.
- B. In the **Requested Coverages** box, the bracketed list of coverages may reflect those coverages applicable. We do request variability to include any future approved coverages in this box.
- C. In the **Fraud Warning** section, the applicable fraud warning may be included and updates to the fraud warning language may be made if the state requires a future change.
- D. In the **Agreement** section, the bracketed reference to employee/member may include the appropriate descriptions of the members eligible for coverage and the bracketed **Work/Membership** may reflect the appropriate reference applicable to the group.
- E. In the signature block, the bracketed license number may be omitted.