

SERFF Tracking Number: MNNP-126931276 State: Arkansas  
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 47603  
Company Tracking Number: HP13GP  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term  
Product Name: LTD 2011  
Project Name/Number: LTD 2011/

## Filing at a Glance

Company: ReliaStar Life Insurance Company

Product Name: LTD 2011

TOI: H11G Group Health - Disability Income

Sub-TOI: H11G.003 Long Term

Filing Type: Form

SERFF Tr Num: MNNP-126931276 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47603

Co Tr Num: HP13GP

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: C.T. Brasch, Dawn Olson

Disposition Date: 01/06/2011

Date Submitted: 12/29/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: LTD 2011

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 01/06/2011

State Status Changed: 01/06/2011

Created By: Dawn Olson

Corresponding Filing Tracking Number:

Filing Description:

We are submitting a new Group Long Term Disability Income Insurance Policy, Certificate and Amendment forms for your review and approval. These forms are new and have not previously been approved or disapproved by your Department. Upon approval, these forms will be marketed to eligible employer groups, union groups, and multiple employer/union trust groups in your state.

These forms are designed to offer multiple options to the group policyholder. Variables are indicated by brackets. A Statement of Variability is included.

Consumer Notice C729GP is included for use with Arkansas residents that are covered under a policy issued in a state

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other than Arkansas. This notice has been previously filed and approved with our other group life and health products.

We will use our previously approved Group Application and Evidence of Insurability forms with this new policy and certificate.

## Company and Contact

### Filing Contact Information

Dawn Olson, Compliance Analyst dawn.olson@us.ing.com  
 P.O. Box 20 612-342-7258 [Phone]  
 Route 7786 612-342-3695 [FAX]  
 Minneapolis, MN 55440-0020

### Filing Company Information

ReliaStar Life Insurance Company CoCode: 67105 State of Domicile: Minnesota  
 P.O. Box 20 Group Code: 229 Company Type:  
 Minneapolis, MN 55440-0020 Group Name: State ID Number:  
 (612) 372-5246 ext. [Phone] FEIN Number: 41-0451140

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$125.00  
 Retaliatory? Yes  
 Fee Explanation: Minnesota charges a flat \$125 for form filings.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	\$125.00	12/29/2010	43295634
ReliaStar Life Insurance Company	\$375.00	01/04/2011	43420637

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/06/2011	01/06/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/03/2011	01/03/2011	Dawn Olson	01/04/2011	01/04/2011

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## Disposition

Disposition Date: 01/06/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Long Term Disability Income Policy	Approved-Closed	Yes
Form	Long Term Disability Income Certificate	Approved-Closed	Yes
Form	Policy Amendment - adding or deleting divisions/employers	Approved-Closed	Yes
Form	Policy Amendment - revising Part B	Approved-Closed	Yes
Form	Policy Amendment - adding or deleting benefits	Approved-Closed	Yes
Form	Policy Amendment - policyholder name change	Approved-Closed	Yes
Form	Policy Amendment - provision change	Approved-Closed	Yes
Form	Certificate Amendment - revising maximum benefit amount	Approved-Closed	Yes
Form	Certificate Amendment - provision change	Approved-Closed	Yes
Form	Consumer Notice for Arkansas Residents	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 01/03/2011

Submitted Date 01/03/2011

Respond By Date

Dear Dawn Olson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Long Term Disability Income Policy, HP13GP (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$500.00. Please submit an additional \$375.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/04/2011  
Submitted Date 01/04/2011

Dear Rosalind Minor,

### Comments:

We have received your objection of January 3rd.

### Response 1

Comments: The additional \$375.00 has now been remitted.

### Related Objection 1

Applies To:

- Long Term Disability Income Policy, HP13GP (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$500.00. Please submit an additional \$375.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you.

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Sincerely,  
C.T. Brasch, Dawn Olson

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## Form Schedule

### Lead Form Number: HP13GP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/06/2011	HP13GP	Policy/Cont	Long Term Disability ract/Fratern Income Policy Certificate	Initial			HP13GP.pdf
Approved-Closed 01/06/2011	HC13GPAR	Certificate	Long Term Disability Income Certificate	Initial			HC13GPAR.pdf
Approved-Closed 01/06/2011	LTD-PA1	Policy/Cont	Policy Amendment - ract/Fratern adding or deleting al divisions/employers Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			LTD-PA1.pdf
Approved-Closed 01/06/2011	LTD-PA2	Policy/Cont	Policy Amendment - ract/Fratern revising Part B al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			LTD-PA2.pdf
Approved-Closed 01/06/2011	LTD-PA3	Policy/Cont	Policy Amendment - ract/Fratern adding or deleting al benefits Certificate: Amendmen t, Insert	Initial			LTD-PA3.pdf

<i>SERFF Tracking Number:</i>	<i>MNNP-126931276</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>ReliaStar Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47603</i>
<i>Company Tracking Number:</i>	<i>HP13GP</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.003 Long Term</i>
<i>Product Name:</i>	<i>LTD 2011</i>		
<i>Project Name/Number:</i>	<i>LTD 2011/</i>		
	Page,		
	Endorseme		
	nt or Rider		
Approved- LTD-PA4	Policy/Cont Policy Amendment - Initial		LTD-PA4.pdf
Closed	ract/Fratern policyholder name		
01/06/2011	al change		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- LTD-PA5	Policy/Cont Policy Amendment - Initial		LTD-PA5.pdf
Closed	ract/Fratern provision change		
01/06/2011	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- LTD-CA1	Certificate Certificate	Initial	LTD-CA1.pdf
Closed	Amendmen Amendment -		
01/06/2011	t, Insert revising maximum		
	Page, benefit amount		
	Endorseme		
	nt or Rider		
Approved- LTD-CA2	Certificate Certificate	Initial	LTD-CA2.pdf
Closed	Amendmen Amendment -		
01/06/2011	t, Insert provision change		
	Page,		
	Endorseme		
	nt or Rider		
Approved- C729GP	Certificate Consumer Notice for Initial		C729GP.pdf
Closed	Amendmen Arkansas Residents		
01/06/2011	t, Insert		
	Page,		
	Endorseme		

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nt or Rider

**RELIASTAR LIFE INSURANCE COMPANY**  
Home Office, Minneapolis, Minnesota 55440

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]  
**POLICY EFFECTIVE DATE:** [June 1, 2011]  
**POLICY ANNIVERSARY DATE:** [June 1, 2012]  
**GOVERNING JURISDICTION:** [State]

ReliaStar Life Insurance Company (ReliaStar Life) will pay the benefits according to the terms and conditions of this policy. This group policy is issued in consideration of the **Policyholder's** application and payment of premiums when due. This policy does not replace or affect any requirements for coverage by any Workers' Compensation or state disability insurance.

This policy is effective on the Policy Effective Date. The first policy year ends on the Policy Anniversary Date. Policy years are determined from the Policy Anniversary. Benefit periods begin at 12:01 a.m. standard time at the **Policyholder's** address and end at 12:00 midnight standard time at the **Policyholder's** address.

READ YOUR POLICY CAREFULLY! This policy is a legal contract between the **Policyholder** and ReliaStar Life, delivered in and governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security **Act** of 1974 (ERISA) and any amendments.

**ENTIRE CONTRACT** - The entire policy consists of all of the following:

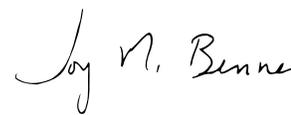
- Part A. **Policyholder** Provisions.
- Part B. The **Insured Persons'** Benefits Section and the Certificate(s) which are made a part of that section.
- Any endorsements, amendments and/or riders issued.
- The **Policyholder's** signed application.
- [- The **Employers'** signed participation agreements, if any.]
- [- The **insured persons'** signed **enrollment forms**, if any.]

This group policy may be changed. Only a designated corporate officer or an Assistant Secretary of ReliaStar Life can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, producer or broker, may change this policy, waive any of its provisions, or bind ReliaStar Life in any way.

Signed for ReliaStar Life at its home office in Minneapolis, Minnesota on the Policy Effective Date.

  
President

\_\_\_\_\_  
Registrar

  
Secretary

This policy provides  
Group Long Term Disability Income Insurance

[Contributory] [Noncontributory]

Nonparticipating

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## PART A. POLICYHOLDER PROVISIONS

### COST OF INSURANCE

The initial premium for this policy is based on the initial rate(s) shown below.

[[Monthly] [Quarterly] rate of [xx%] of [monthly covered payroll] [monthly benefit]]

[[Monthly] [Quarterly] cost of [\$xx] [per insured person]]

[See rates on Premium Rate Notification (PRN) issued effective [June 1, 2011].]

[[Basic Benefit:] [Monthly] [Quarterly] rate of [\$xx] per \$100 of [monthly benefit] [monthly covered payroll]]

[[Buy-Up Benefit:] [Monthly] [Quarterly] rate of [\$xx] per \$100 of [monthly benefit] [monthly covered payroll]]

[[Buy-Up Benefits:] [25-80%] [pre-tax] [post-tax] benefit: [Monthly] [Quarterly] rate of [\$xx] per \$100 of [monthly benefit] [monthly covered payroll]]

[[25-80%] [pre-tax] [post-tax] benefit: [Monthly] [Quarterly] rate of [\$xx] per \$100 of [monthly benefit] [monthly covered payroll]]

[[25-80%] [pre-tax] [post-tax] benefit: [Monthly] [Quarterly] rate of [\$xx] per \$100 of [monthly benefit] [monthly covered payroll]]

[[Basic Benefit:]

Age	[Monthly] [Quarterly] rate per \$100 of [monthly benefit] [monthly covered payroll]
Less than age 25	[\$xx]
25-29	[\$xx]
30-34	[\$xx]
35-39	[\$xx]
40-44	[\$xx]
45-49	[\$xx]
50-54	[\$xx]
55-59	[\$xx]
60-64	[\$xx]
65-69	[\$xx]
70 and over	[\$xx]]

[[Buy-Up Benefit:]

Age	[Monthly] [Quarterly] rate per \$100 of [monthly benefit] [monthly covered payroll]
Less than age 25	[\$xx]
25-29	[\$xx]
30-34	[\$xx]
35-39	[\$xx]
40-44	[\$xx]
45-49	[\$xx]
50-54	[\$xx]
55-59	[\$xx]
60-64	[\$xx]
65-69	[\$xx]
70 and over	[\$xx]]

**[[Buy-Up Benefits:]**

Age	[25-80%] [pre-tax] [post-tax] benefit: [Monthly] [Quarterly] rate per \$100 of [monthly benefit] [monthly covered payroll]	[25-80%] [pre-tax] [post-tax] benefit: [Monthly] [Quarterly] rate per \$100 of [monthly benefit] [monthly covered payroll]
Less than age 25	[\$xx]	[\$xx]
25-29	[\$xx]	[\$xx]
30-34	[\$xx]	[\$xx]
35-39	[\$xx]	[\$xx]
40-44	[\$xx]	[\$xx]
45-49	[\$xx]	[\$xx]
50-54	[\$xx]	[\$xx]
55-59	[\$xx]	[\$xx]
60-64	[\$xx]	[\$xx]
65-69	[\$xx]	[\$xx]
70 and over	[\$xx]	[\$xx]

**[Monthly Covered Payroll]** means the total amount of **monthly earnings** for which **insured persons** are insured under the policy.]

**INITIAL RATE GUARANTEE AND RATE CHANGES**

A change in premium rates will not take effect before [June 1, 2012].

However, **we** may change premium rates at any time for reasons which affect the risk assumed, including but not limited to any of these:

- A change occurs in the policy design.
- The number of **insured persons** changes by [10-25%] or more.
- A new **law** or a change in any existing **law** is enacted which applies to the policy.

**We** will notify the **Policyholder** in writing at least [30-60] days before a premium rate is changed. A change may take effect on an earlier date when both the **Policyholder** and **we** agree.

**WHEN PREMIUM IS DUE**

Premium Due Dates: [06/01/2011] and the [first-last] day of each [calendar month] [quarter] thereafter.

The **Policyholder** must send all premiums to **us** on or before their respective due date. The premium must be paid in United States dollars to **our** home office.

**WAIVER OF PREMIUM**

**We** do not require premium payment for an **insured person's** coverage while that **insured person** is receiving Long Term Disability payments under the policy.

**PREMIUM INCREASES OR DECREASES**

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

Premium changes for new **insured persons** or for increases in insurance amounts will begin on the premium due date which coincides with or next follows the date of the addition or the change. Premium charges for terminated persons will end, and decreases for insurance amounts will begin, on the premium due date which coincides with or next follows the termination or the change in amount. This method of charging premium will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate pursuant to the applicable effective date or termination provisions of the policy.

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

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

## **GRACE PERIOD**

If a premium is not paid by its due date, the **Policyholder** has a **grace period** of [31-180] days from the due date in which to pay it. **We** must receive full payment by the [31st-180th] day. During the **grace period** the policy will remain in force, unless the **Policyholder** gives **us** written notice of termination in advance of the date of termination. If full payment is not received by **us** by the end of the **grace period**, the policy will automatically terminate at the end of the **grace period**. The **Policyholder** is required to pay premiums for any period the policy was in force during the **grace period**.

## **[INFORMATION REQUIRED FROM THE POLICYHOLDER**

The **Policyholder** must provide **us** with all of the following on a regular basis:

- Information about persons:
  - who are eligible to become insured, and
  - [– who **enroll** for coverage [and their initial amount of coverage,] and]
  - whose amounts of coverage change, and
  - whose coverage ends.
- Occupational and salary information and any other information that may be required to manage a claim.
- Any other information that may be reasonably required.

Any **Policyholder** records that have a bearing, in **our** opinion, on the policy will be available for review by **us** at any reasonable time as determined by **us**.]

## **[INFORMATION REQUIRED FROM THE POLICYHOLDER**

The **Policyholder** must provide **us** with detailed information about persons who are eligible to become insured under the policy, information about **insured persons**, and any other information that may be reasonably required.

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

## **INFORMATION PROVIDED BY US**

**We** will furnish the **Policyholder** with a Certificate of Coverage which outlines the benefits under the policy. The [**Policyholder**] [**Employer**] will make available a Certificate of Coverage to each **insured person**.

## **REPRESENTATIONS NOT WARRANTIES**

A copy of the **Policyholder's** application will be attached to the policy when issued. Unless fraudulent, all statements made by the **Policyholder** [and **Employer**] are considered representations and not warranties.

## **INCONTESTABILITY**

The validity of the policy can not be contested after it has been in force for two years from the Policy Effective Date, except when either of the following occurs:

- Premium has not been paid.
- Fraudulent misrepresentations are made.

## **ELIGIBLE NEW INSURED PERSONS**

Eligible new **insured persons** will be added to the group according to the terms and provisions of the policy.

### **[AMENDING OR CANCELING THE POLICY**

The policy can be canceled either by **us** or by the **Policyholder**.

**We** may amend or cancel the policy for any of the following reasons:

1. [There is less than [5-100%] participation of those eligible persons who pay all or part of their premium for the policy.] [There is less than 100% participation of those eligible persons working for a **Policyholder** with 2 to 5 eligible persons.]
- [2. The participation requirement is not met for a **Policyholder** with 6 to 9 eligible persons who pay a part of their premium for the policy:
  - for a **Policyholder** with 6 eligible persons, at least 5 must be enrolled;
  - for a **Policyholder** with 7 eligible persons, at least 6 must be enrolled;
  - for a **Policyholder** with 8 eligible persons, at least 6 must be enrolled;
  - for a **Policyholder** with 9 eligible persons, at least 7 must be enrolled.]
- [3.] There is less than 100% participation of those eligible persons for a **Policyholder** paid plan.
- [4.] The **Policyholder** does not promptly provide **us** with information that is reasonably required.
- [5.] The **Policyholder** fails to perform any of its obligations that relate to the policy.
- [6.] Fewer than [2-10] persons are insured under the policy.
- [7.] The premium is not paid in accordance with the provisions of the policy.
- [[8.] The **Policyholder** does not promptly report to **us** the names of any persons who are added or deleted from the eligible class(es).]
- [9.] **We** determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the **Policyholder** and/or its persons.
- [10.] The **Policyholder** fails to pay the full premium due by the end of the **grace period**.

**We** reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If **we** amend or cancel the policy for reasons other than the **Policyholder's** failure to pay premiums, written notice will be mailed to the **Policyholder** at least [30-60] days prior to the amendment date or cancellation date. The **Policyholder** may cancel the policy if the amendments are unacceptable.

The **Policyholder** may cancel the policy by written notice delivered to **us** at **our** home office at least [30-60] days prior to the cancellation date. When both the **Policyholder** and **we** agree, the policy can be canceled on an earlier date. If the **Policyholder** or **we** cancel the policy, coverage will end at 12:00 midnight standard time at the **Policyholder's** address on the last day of coverage.

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

### **[CANCELING THE POLICY [OR AN EMPLOYER'S PLAN OF COVERAGE UNDER THE POLICY]**

The policy [or an **Employer's** plan of coverage under the policy] can be canceled by **us** or by the **Policyholder**.

**We** may cancel the policy [or an **Employer's** plan of coverage under the policy] on any premium due date after the first Policy Anniversary Date by giving at least [30-60] days advance written notice of termination to the **Policyholder**.

If fewer than [10-500] persons are insured under the policy [or an **Employer's** plan of coverage under the policy], **we** may cancel the policy [or an **Employer's** plan of coverage under the policy] at any time by giving at least [30-60] days advance written notice of termination to the **Policyholder**.

**We** reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

The **Policyholder** may cancel the policy [or an **Employer's** plan of coverage under the policy] by written notice delivered to **us** at **our** home office at least [30-60] days prior to the cancellation date. When both the **Policyholder** and **we** agree, the policy [or an **Employer's** plan of coverage under the policy] can be canceled on an earlier date. If the **Policyholder** or **we** cancel the policy [or an **Employer's** plan of coverage under the policy], coverage will end at 12:00 midnight standard time at the **Policyholder's** address on the last day of coverage.

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

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

The policy or an **Employer's** plan of coverage under the policy can be canceled by **us** or by the **Policyholder**.

**We** may amend or cancel the policy or an **Employer's** plan of coverage under the policy for any of the following reasons:

- The **Policyholder** or **Employer** does not promptly provide **us** with information that is reasonably required.
- The **Policyholder** fails to perform any of its obligations that relate to the policy.
- Fewer than [10-500] persons are insured under the policy.
- The premium is not paid in accordance with the provisions of the policy.
- **We** determine that there is a significant change in the size, occupation or age of the eligible class(es).
- The **Policyholder** fails to pay the full premium due by the end of the **grace period**.

**We** reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If **we** amend or cancel the policy or an **Employer's** plan of coverage under the policy for reasons other than the **Policyholder's** failure to pay premiums, written notice will be mailed to the **Policyholder** at least [30-60] days prior to the amendment date or cancellation date. The **Policyholder** may cancel the policy or an **Employer's** plan of coverage under the policy if the amendments are unacceptable.

The **Policyholder** may cancel the policy or an **Employer's** plan of coverage under the policy by written notice delivered to **us** at **our** home office at least [30-60] days prior to the cancellation date. When both the **Policyholder** and **we** agree, the policy or an **Employer's** plan of coverage under the policy can be canceled on an earlier date. If the **Policyholder** or **we** cancel the policy or an **Employer's** plan of coverage under the policy, coverage will end at 12:00 midnight standard time at the **Policyholder's** address on the last day of coverage.

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

**REINSTATEMENT**

**We** will not reinstate the policy after it has canceled. To become insured after insurance has stopped, the **Policyholder** must submit a new application.

**[ASSIGNMENT**

The **Policyholder** may assign the policy; however, the **Policyholder** is required to advise all certificateholders of any assignment in writing, via certified mail. None of the **insured persons'** rights will be affected. Such assignment will not affect **us** until **we** receive written notice at **our** home office and give **our** written approval.]

**[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED]**

**[PARTICIPATING EMPLOYERS]**

NAME	LOCATION (CITY AND STATE)
[None]	
[XYZ Company]	[Columbus, Ohio]

### **[BUSINESS PROTECTION BENEFIT**

A monthly Business Protection Benefit will be paid to the **Employer** to compensate for business revenue lost as a result of an **insured person's** disability if that **insured person** is receiving a **monthly payment** under the policy, and is one of the following:

- A sole proprietor of the **Employer** if the **Employer** is a sole proprietorship.
- A general partner of the **Employer** if the **Employer** is a partnership.
- A member of a limited liability company if the **Employer** is a limited liability company.

The elimination period for the Business Protection Benefit is the greater of the following:

- The elimination period for the **insured person's** Long Term Disability benefits under the policy.
- 90 consecutive days.

The amount of the Business Protection Benefit payment is the **monthly payment** the **insured person** is receiving under the policy; however, the Business Protection Benefit will not be reduced by **deductible sources of income**.

The Business Protection Benefit will end on the earliest of the following:

- The date the **insured person** is no longer disabled.
- The date the **insured person** ceases to be a sole proprietor, general partner, or member of a limited liability company.
- The date the Business Protection Benefit has been paid for [3-60] months.

[The PRE-EXISTING LIMITATION provision of the policy applies to this Business Protection Benefit, as of the effective date of the Business Protection Benefit coverage for each **insured person**.]

[In order for the policy to include a Business Protection Benefit for an **insured person**, that person must submit an **evidence of insurability** form to **us** for approval. The Business Protection Benefit coverage for that person will become effective on the later of the following:

- The date the Business Protection Benefit has been added to the policy.
- The date **we** approve the Business Protection Benefit coverage for that person.]]

### **[TEMPORARY WORK BENEFIT**

**We** will pay the **Employer** a one-time benefit of \$1,000 to be used to supplement the cost of a temporary worker when an **insured person** under the policy is disabled and receiving disability benefits from **us**.

The **Employer** qualifies for this Temporary Work Benefit when all of the following are true:

- An **insured person** is disabled according to the terms of the policy.
- The **insured person** has satisfied the elimination period for the policy.
- The **insured person's** claim is approved and the **insured person** is receiving disability benefits under the policy.

This one-time payment will be made to the **Employer** no later than 90 days following the date the first disabled **insured person** under the policy receives his or her first Long Term Disability payment under the policy.

The Temporary Work Benefit is paid only once while the policy is in force, including any renewals.]]

## PART B. INSURED PERSONS' BENEFITS SECTION

**POLICYHOLDER:** [ABC Company]

**GROUP POLICY NUMBER:** [12345-6LTD]

The Certificates specified in the Certificate Index below are made a part of the policy.

The Certificates are identified by a B-number. Amendments, Endorsements and Riders, if any, amending the provisions of the Certificates are also made a part of the policy. The Certificates, Amendments, Endorsements and Riders are made a part of the policy from the Effective Date(s) listed below. The Class(es) of **Insured Persons** to whom provisions apply are also listed in the Certificate Index.

### CERTIFICATE INDEX

<b>Class of Insured Persons</b>	<b>Certificate Number</b>	<b>Effective Date</b>
[All Eligible <b>Employees</b>	B-4444	June 1, 2011]

### [AMENDMENT/ENDORSEMENT/RIDER INDEX

<b>Class of Insured Persons</b>	<b>Certificate Number</b>	<b>Amendment/Endorsement/ Rider Number</b>	<b>Effective Date</b>
All <b>Employees</b>	B-4444	RB-6666	June 1, 2012
Wisconsin Residents	B-4444	R-08151d	June 1, 2011]

# GROUP LONG TERM DISABILITY INCOME INSURANCE CERTIFICATE OF COVERAGE

**RELIASTAR LIFE INSURANCE COMPANY**  
20 Washington Avenue South  
Minneapolis, Minnesota 55401

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]  
**POLICY EFFECTIVE DATE:** [June 1, 2011]  
**[EMPLOYER:** [XYZ Employer]]  
**[EMPLOYER PLAN EFFECTIVE DATE:** [June 1, 2011]]  
**DATE:**  
**GOVERNING JURISDICTION:** Arkansas

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the group policy listed above to the **Policyholder**. The policy is available for **you** to review if **you** contact the **Policyholder** for more information. **This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate of Coverage replaces any other certificates ReliaStar Life may have given **you** under the policy.

The Certificate of Coverage summarizes and explains the parts of the policy which apply to **you**. The Certificate of Coverage is part of the group policy but by itself is not a policy. **Your** coverage may be changed under the terms and conditions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security **Act** of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the policy, all days begin at 12:01 a.m. standard time at the **Policyholder's** address and end at 12:00 midnight standard time at the **Policyholder's** address.

**The policy does not replace or affect any requirements for coverage by any Workers' Compensation or state disability insurance. The policy [covers] [does not cover] disabilities due to an occupational sickness or injury.**

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Registrar

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## BENEFITS AT A GLANCE

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

**EMPLOYER:** [XYZ Employer]

**GROUP POLICY NUMBER:** [12345-6LTD]

**[ACCOUNT NUMBER:** [2]]

[Refer to the attached Schedule of Benefits.]

### **[ELIGIBLE CLASS(ES)**

[All **employees**] in **active employment** with the **Employer** in the United States [or at an **Employer** location in [Canada or France]].

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

Temporary and seasonal workers are excluded from coverage.]

### **[MINIMUM HOURS REQUIREMENT**

[30 hours per week]]

### **[WAITING PERIOD**

For persons in an eligible class on or before the policy effective date: [None] [A continuous period of [1-365 days] of **active employment**.] [End of the month in which **you** complete a continuous period of [1-365 days] of **active employment**.] [End of the month in which **you** begin **active employment**.]

For persons entering an eligible class after the policy effective date: [A continuous period of [1-365 days] of **active employment**.] [End of the month in which **you** complete a continuous period of [1-365 days] of **active employment**.] [End of the month in which **you** begin **active employment**.]

### **[REHIRE**

If **your** employment ends and **you** are rehired within [1-12 months], **your** previous work while in an eligible class will apply toward the **waiting period**. All other policy provisions apply.]

### **[WAIVE THE WAITING PERIOD**

If **you** have been continuously employed by **your Employer** for a period of time equal to **your waiting period**, we will waive **your waiting period** when **you** enter an eligible class.]

### **[CREDIT PRIOR SERVICE**

We will apply any prior period of work with **your Employer** toward the **waiting period** to determine **your** eligibility date.]

### **[WHO PAYS FOR THE COVERAGE**

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

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

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

### **[WHO PAYS FOR THE COVERAGE**

[Option 1 Coverage]: **Your Employer** pays the cost of **your** coverage.

[Option 2 Coverage]: **You** and **your Employer** share the cost of **your** coverage.]

### **[WAIVER OF PREMIUM**

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

## BENEFITS AT A GLANCE

### **[ELIMINATION PERIOD**

[[1-730] consecutive days.]

[[1-730] consecutive days for disability due to **injury**.

[1-730] consecutive days for disability due to **sickness**.]

[The latest of the following:

- [1-730] consecutive days for disability due to **injury**.
- [1-730] consecutive days for disability due to **sickness**.
- The date **your** [short term disability payments or] **salary continuation or accumulated sick leave** payments end, if applicable. [For paid time off, **we** will count only the time in excess of [2-10 days] for each period of disability.]]

[[Option A]: [1-730] consecutive days.

[Option B]: [1-730] consecutive days.]

The elimination period begins on the first day of **your** disability.

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

### **[ACCUMULATION OF ELIMINATION PERIOD**

Elimination period: [30-365] consecutive days.

Accumulation period: [60-730] consecutive days.

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

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

### **[MONTHLY BENEFIT**

[25-80%] of **monthly earnings** to a **maximum benefit** of [\$500-40,000] per month.

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

### **[MAXIMUM BENEFIT WITHOUT EVIDENCE OF INSURABILITY**

[\$1,000-20,000] per month]

### **[MONTHLY EARNINGS**

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

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

- The 12 full calendar months period of **your** employment with **your Employer** just prior to the date **your** disability begins.
- The period of actual employment with **your Employer**.]

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

## BENEFITS AT A GLANCE

### [MAXIMUM PERIOD OF PAYMENT [- OPTION A]

For a disability which begins before **you** reach age 60, the **maximum period of payment** will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	Social Security Normal Retirement Age (SSNRA)*
Before 1938 .....	65 years
1938 .....	65 years and 2 months
1939 .....	65 years and 4 months
1940 .....	65 years and 6 months
1941 .....	65 years and 8 months
1942 .....	65 years and 10 months
1943-1954 .....	66 years
1955 .....	66 years and 2 months
1956 .....	66 years and 4 months
1957 .....	66 years and 6 months
1958 .....	66 years and 8 months
1959 .....	66 years and 10 months
1960 and after .....	67 years

For a disability which starts on or after **you** reach age 60, the **maximum period of payment** will be determined according to the following table:

Your Age When Disability Begins	Maximum Period of Payment
Age 60 .....	60 months or to SSNRA*, whichever is greater
Age 61 .....	48 months or to SSNRA*, whichever is greater
Age 62 .....	42 months or to SSNRA*, whichever is greater
Age 63 .....	36 months or to SSNRA*, whichever is greater
Age 64 .....	30 months or to SSNRA*, whichever is greater
Age 65 .....	24 months
Age 66 .....	21 months
Age 67 .....	18 months
Age 68 .....	15 months
Age 69 and over .....	12 months

\*Age at which **you** are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.]

### [REGULAR OCCUPATION PERIOD

[1-5 Year(s)]

### [TOTAL BENEFIT CAP

If **you** are eligible to receive payments under the policy in addition to **your monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings** [unless an excess amount is payable as a result of a Cost of Living Adjustment]. [However, if **you** are participating in a **vocational rehabilitation plan**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings** [unless an excess amount is payable as a result of a Cost of Living Adjustment].]

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

## DEFINITIONS

[**ACCIDENT** or **ACCIDENTAL** means a sudden, unexpected event that was not reasonably foreseeable.]

[**ACCREDITED INSTITUTION** means any university, college or trade school, which is accredited by a regional accrediting agency that is recognized by the United States Department of Education.]

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

To be in **active employment**, **your** work site must be one of the following:

- **Your Employer's** usual place of business.
- An alternative work site at the direction of **your Employer**, including **your** home.
- A location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment**.

Temporary and seasonal workers are excluded from coverage.]

[**ACTIVITIES OF DAILY LIVING** means:

- **BATHING** – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.
- **DRESSING** – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **TOILETING** – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **TRANSFERRING** – moving into and out of a bed, chair or wheelchair.
- **MOBILITY** – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.
- **CONTINENCE** – the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **EATING** – feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table).]

[**APPROPRIATE CARE** means that all of the following are true:

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

[**CHILD** means a natural, step, foster or adopted child under age 15 who lives with **you** and is primarily dependent on **you** for financial support.]

[**COBRA** means the Consolidated Omnibus Budget Reconciliation **Act**.]

[**COBRA MEDICAL COVERAGE** means the continuation of **medical coverage** under **your Employer's** plan as provided for under the Consolidated Omnibus Budget Reconciliation **Act (COBRA)**.]

[**COGNITIVE IMPAIRMENT** means **you** have a deterioration or loss in intellectual capacity, resulting from **injury, sickness, Alzheimer's disease** or similar forms of irreversible dementia and **you** need another person's active help or verbal guidance for **your** own protection or for the protection of others. The deterioration or loss will be based on clinical evidence and/or clinical tests, according to generally accepted medical standards, that reliably measure **your** impairment. Cognitive impairments which begin prior to the effective date of **your** coverage will not be covered.]

[**CONTEST** means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** notify **you** in writing that such coverage was therefore never effective. This is subject to the INCONTESTABILITY provision. [Any premium **you** paid will be refunded to **you**.]

## DEFINITIONS

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

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

**DOCTOR** means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:

- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the **laws** and regulations of the jurisdiction where treatment occurred.

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

**[ELIGIBLE STUDENT** means **your** unmarried dependent child under the age of [23-27] who is attending an **accredited institution** beyond the 12th grade level on a full-time basis.]

**[ELIGIBLE SURVIVOR** means **your** spouse, if living; otherwise, **your** children under age 25. ["Spouse" includes **your** domestic partner if **you** have completed and signed [an affidavit] [a declaration] of domestic partnership on a form acceptable to **your Employer.**]

**[EMPLOYEE** means a person who is a citizen or legal resident of the United States in **active employment** with the **Employer** in the United States [or at an **Employer** location in [Canada or France]].]

**[EMPLOYER** means the **Policyholder** and includes any division, subsidiary or affiliated company named in the policy.]

**[EMPLOYER** means the entity that has been approved by **us** for coverage under the policy issued to the **Policyholder**. Approval by **us** of an **Employer's** plan of coverage under the policy is as recorded and maintained in **our** underwriting file(s) for the policy.]

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

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

**[EVIDENCE OF INSURABILITY** means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage.]

**[EVIDENCE OF INSURABILITY FORM** means the supplement to the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history. Only the **evidence of insurability form** provided by **us** will be accepted. Completion of the **evidence of insurability form** is at **your** own expense.]

**[FAMILY MEMBER** means an individual who can be claimed as a dependent by **you** for federal income tax purposes.]

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

- [60-85%] of **your indexed monthly earnings**, if **you** are working.
- [60-85%] of **your indexed monthly earnings**, if **you** are not working.]

**[GAINFUL OCCUPATION** means an occupation that is or can be expected to provide **you** with an income of the lesser of **your gross monthly payment** or [\$8,333-10,000] per month within [12-24] months of **your** return to work.]

**[GAINFUL OCCUPATION** means an occupation that is or can be expected to provide **you** with an income of at least [\$1,000-5,000] per month, within 12 months of **your** return to work.]

**GRACE PERIOD** means the [31-180] day period following the premium due date during which premium payment for the policy may be made by the **Policyholder**.

## DEFINITIONS

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

**[HOSPITAL CONFINED** means **you** are confined as an in-patient in a **hospital, health facility or institution**. In-patient means **you** are physically confined for an overnight stay, as a registered bed patient.]

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

**[IMPAIRED or IMPAIRMENT** means that **you** are prevented or limited from performing the **material and substantial duties** of **your regular occupation**, and as a result, **you** suffer an involuntary earnings loss of 20% or more of **your monthly earnings**.

**We** will consider **you** prevented or limited from performing the **material and substantial duties** of **your regular occupation** if as a direct result of testing positive for an **infectious and contagious disease** any of the following occur:

- Restrictions are placed on **you** by a licensing or privileging board, **law** or regulation.
- **You** lose **your** license, certification or privileges.
- **You** submit proof in a form acceptable to **us** that **you** have suffered an involuntary loss of patients or loss of work assignments which loss cannot be replaced through reasonable accommodation.]

**[INDEXED MONTHLY EARNINGS** means **your monthly earnings** adjusted on each anniversary of benefit payment by the lesser of [1-10%] or the current annual percentage increase in the Consumer Price Index. **Your indexed monthly earnings** may increase or remain the same, but will never decrease.

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

**[INFECTIOUS AND CONTAGIOUS DISEASE** means a disease for which both of the following are true:

- It is classified by the Centers for Disease Control and Prevention (CDC), located in Atlanta, Georgia, or its successor, as infectious and contagious.
- It is reasonably considered to pose an immediate or potential life-threatening risk to others while **you** perform **your regular occupation**.]

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

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

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

**[LEAVE OF ABSENCE** means **you** are absent from **active employment** for a period of time that has been agreed to in advance in writing by **your Employer**. **Your** normal vacation time or any period of disability is not considered a **leave of absence**.]

**[MATERIAL AND SUBSTANTIAL DUTIES** means duties that are normally required for the performance of **your regular occupation** and that cannot be reasonably be omitted or modified, except that if **you** are required to work on average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** have the capacity to work 40 hours per week.]

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

## DEFINITIONS

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

- During the **regular occupation period**, the greatest extent of work **you** are able to do in **your regular occupation**.
- Beyond the **regular occupation period**, the greatest extent of work **you** are able to do in any occupation for which **you** are reasonably fitted by education, training or experience.]

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

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

**[MEDICAL COVERAGE** means insurance provided under **your Employer's** group health or medical plan that pays for **your** medical, hospital or surgical expenses.]

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

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

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

**[MONTHLY PAYMENT** means the monthly benefit amount.]

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

**[PART-TIME BASIS** means the ability to work and earn from 20% through [75-80%] of **your indexed monthly earnings**. Ability is based on capacity and not market availability.]

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

**[POLICYHOLDER** means the **Employer** to whom the policy is issued and who sponsors the coverage for its **employees**.]

**[POLICYHOLDER** means the entity to whom the policy is issued.]

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

- Received medical treatment or consultation.
- Taken or were prescribed drugs or medicine.
- Received care or services, including diagnostic measures.

**[PROGRESSIVE DISEASE** means a non-infectious disease or disorder of indefinite duration that causes **you** to gradually become disabled as the disease or disorder becomes more severe or the symptoms of the disease become more frequent and impair **your** ability to perform **your regular occupation**.]

**RECURRENT DISABILITY** means a disability for which both of the following are true:

- It is caused by a worsening in **your** condition.
- It is due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment**.

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

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

## DEFINITIONS

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

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

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

**[SPECIAL CONDITIONS** means any of the following:

- Musculoskeletal and connective tissue disorders of the neck, back and shoulders including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including herniated or ruptured discs not requiring surgery, as well as sprains and strains of joints and adjacent muscles, *except* for any of the following:
  - Scoliosis.
  - Spinal fractures.
  - Osteopathies.
  - Traumatic spinal cord necrosis.
  - Radiculopathies, documented by electromyogram.
  - Spondylolisthesis, grade II or higher.
  - Myelopathies and myelitis.
  - Demyelinating diseases.
  - Spinal tumors, malignancy, or vascular malformations.
- Chronic fatigue syndrome.
- Environmental allergic illness including but not limited to sick-building syndrome and multiple chemical sensitivity.
- Carpal tunnel syndrome not requiring surgery.
- Fibromyalgia.
- Myofascial pain syndrome.]

**[STAND-BY HELP** means **you** must have hands-on (active) help from another person with all or most of the activity.]

**[TEMPORARY LAYOFF** means **you** are absent from **active employment** for a period of time that has been agreed to in advance in writing by **your Employer**. **Your** normal vacation time or any period of disability is not considered a **temporary layoff**.]

**[TERMINAL ILLNESS** means a diagnosed illness that, according to generally accepted medical standards, is expected to result in death within 12 months.]

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

**[VOCATIONAL REHABILITATION PLAN** means a written plan that a vocational rehabilitation professional, designated by **us**, prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the certificate.]

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

**WE, US** and **OUR** means ReliaStar Life Insurance Company.

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

## GENERAL PROVISIONS

### CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include riders, endorsements and/or amendments. It tells **you**:

- The coverage to which **you** may be entitled.
- To whom **we** will make a payment.
- The limitations, exclusions and requirements that apply within the policy.

### ELIGIBILITY DATE

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

- The policy effective date.
- The day after **you** complete **your** waiting period.

### [WHEN COVERAGE BEGINS

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

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

- The date **you** are eligible for coverage, if **you enroll** for insurance on or before that date.
- The [first day of the month following the] date **you enroll** for insurance, if **you enroll** within [31-60] days after the date **you** become eligible for coverage.
- The [first day of the month following the] date **we** approve **your evidence of insurability form**, if **evidence of insurability** is required.]

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

### [WHEN COVERAGE BEGINS

[Option 1 Coverage:] [The **Policyholder**] [**Your Employer**] pays 100% of the cost of [Option 1 coverage]. **You** will automatically be covered for the [Option 1] amount shown in the BENEFITS AT A GLANCE at 12:01 a.m. standard time at the **Policyholder's** address on the date **you** are eligible for coverage.

[Option 2 Coverage:] **You** and [the **Policyholder**] [**your Employer**] share the cost of [Option 2 coverage]. If **you** are eligible for and **enroll** for [Option 2 coverage], [Option 2 coverage] will be effective at 12:01 a.m. standard time at the **Policyholder's** address on the latest of the following:

- The date **you** are eligible for [Option 2 coverage], if **you enroll** for [Option 2 coverage] before that date.
- The [first day of the month following the] date **you enroll** for [Option 2 coverage], if **you enroll** on or within [31-60] days after the date **you** become eligible for [Option 2 coverage].
- The [first day of the month following the] date **we** approve **your evidence of insurability form**, if **evidence of insurability** is required.

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

### CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** [or if **you** are on a covered [**temporary layoff** or] **leave of absence**]. If **you** are not in **active employment** due to **injury** or **sickness**, any increased or additional coverage will begin on the date **you** return to **active employment**.

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

## GENERAL PROVISIONS

### [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

**Evidence of insurability** is required in any of these situations:

- **You** are a late enrollee, which means **you enroll** for coverage more than [31-60] days after the date **you** are eligible for coverage.
- **You** voluntarily canceled **your** coverage and are reapplying.
- [• **You** previously converted **your** coverage and are surrendering **your** conversion coverage to reapply as an eligible **insured person**.]
- [• **You enroll** for a monthly benefit amount greater than the MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY as shown in the BENEFITS AT A GLANCE, when **you** first become eligible for coverage under the policy.]
- [• **You enroll** to increase **your** monthly benefit by any amount during the policy year.]
- [• **You enroll** to increase **your** monthly benefit by more than [\$100-1,000] during an [annual] enrollment period.]
- [• **You enroll** to increase **your** monthly benefit by more than [one-two] benefit levels during an [annual] enrollment period.]
- [• During an [annual] enrollment period **you** change [**your** Elimination Period election to a shorter period] [or] [**your** Maximum Period of Payment election to a longer period].]

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

[For **your maximum benefit** in excess of [\$1,000-20,000], **you** must submit an **evidence of insurability form**. **You** will be covered for **your maximum benefit** in excess of [\$1,000-20,000] on the later of the following dates:

- The date **we** approve **your evidence of insurability form**.
- The date **your maximum benefit** in excess of [\$1,000-20,000] is effective.]]

### [LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

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

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

- The leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments.
- The leave period permitted by applicable state **law**.

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if premium is paid, **your** coverage will be continued through the end of the [month] [1-12 months] [that immediately follows the month] in which **your leave of absence** begins.

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

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

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

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

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

## GENERAL PROVISIONS

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

### [TEMPORARY LAYOFF [OR LABOR STRIKE]

If **you** are not in **active employment** due to a **temporary layoff**, and if premium is paid, **you** will be covered through the end of the [month] [1-12 months] [that immediately follows the month] in which **your temporary layoff** begins.

[If **you** are not in **active employment** due to a labor strike, and if premium is paid, **you** will be covered through the end of the [month] [1-12 months] [that immediately follows the month] in which the labor strike begins.]]

### WHEN YOUR COVERAGE ENDS

**Your** coverage under the policy ends on the earliest of the following dates:

- The date the policy is canceled.
- The date **you** are no longer in an eligible class.
- The date **your** eligible class is no longer covered.
- The end of the period for which **you** paid premiums, if **you** stop making a required premium contribution.]
- The end of the **Policyholder's grace period**, if the **Policyholder** does not remit premium to **us** by the end of such period.
- The last day **you** are in **active employment** [except as provided under a covered **leave of absence** [or **temporary layoff**] [or labor strike].]

**We** will provide coverage for a **payable claim** that occurs while **you** are covered under the policy. Termination of the policy during a disability will have no effect on a **payable claim**.

### [CONVERSION

[(Not available to residents of CO, FL, IN, LA, MI, NY, OR, SD or WV)]

If **your** coverage stops under the policy, **you** may have a conversion right. The conversion right allows **you** to obtain long term disability income insurance without **evidence of insurability**.

**You** may convert **your** coverage if it stops under the policy for any of the following reasons:

- **You** resign.
- **You** are terminated for cause.
- **You** are laid-off.
- **You** go on a **leave of absence**.

**You** do not have to supply **evidence of insurability** in order to convert **your** coverage. **You** must have been covered for at least 12 consecutive months prior to **your** coverage terminating under the policy. The 12 months can be a combination of insurance under the policy and a prior plan of group long term disability coverage, whether insured or self-funded, sponsored by **your Employer**.

**You** must apply for conversion and pay the first premium within 31 days after termination of **your** coverage under the policy. If approved, **your** long term disability conversion insurance coverage will become effective on the date after **your** coverage under the group policy ends. The benefits and amounts of insurance under the conversion coverage may differ from those under the group policy. **We** reserve the right to have **your** conversion coverage issued by another insurance company.

**You** may not convert **your** coverage if **your** coverage terminates for any of the following reasons:

- Termination of the policy.
- The policy is amended to exclude from coverage the class of **insured persons** to which **you** belong.
- **You** no longer belong to a class eligible for coverage under the policy.
- **You** retire.
- **You** fail to pay any contributions required for **your** coverage.
- **You** are disabled under the terms of the policy.

If **you** become covered for long term disability benefits under another group plan within 31 days after termination of **your** coverage under the group policy, **you** are not eligible to convert **your** coverage.]

## GENERAL PROVISIONS

### TIME LIMITS FOR LEGAL PROCEEDINGS

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

### REPRESENTATIONS NOT WARRANTIES

**We** consider any statements the **Policyholder** [and **your Employer**] and **you** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless both of the following are true:

- The statement is in writing and is signed by **you**.
- A copy of that statement is given to **you** or **your** beneficiary, or **your** personal representative.

### INCONTESTABILITY

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

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

### CLERICAL ERROR

Clerical error or omission by **us** or by the **Policyholder** [or **your Employer**] will not:

- Prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy.
- Cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

If the **Policyholder** [or **your Employer**] gives **us** information about **you** that is incorrect, **we** will do both of the following:

- Use the facts to decide whether **you** have coverage under the policy and in what amounts.
- Make a fair adjustment of the premium.

### MISSTATEMENT OF AGE

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

### WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

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

### AGENCY

For purposes of the policy, the **Policyholder** [and **your Employer**] acts on [its] [their] own behalf or as **your** agent. Under no circumstances will the **Policyholder** [or **your Employer**] be deemed **our** agent.

# LONG TERM DISABILITY BENEFIT INFORMATION

## DEFINITION OF DISABILITY

[You are considered disabled when we review your claim and determine that, due to your sickness or injury, both of the following are true:

- You are unable to perform all the **material and substantial duties** of your regular occupation.
- You have a 20% or more loss in **your indexed monthly earnings.**]

[You are considered disabled when we review your claim and determine that, due to your sickness or injury, either of the following is true:

- You are unable to perform all the **material and substantial duties** of your regular occupation.
- **Your disability earnings** if any, are less than [75-80%] of **your indexed monthly earnings.**]

[You are considered disabled when we review your claim and determine that, due to your sickness or injury, all of the following are true:

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

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

- You are unable to perform all the **material and substantial duties** of your regular occupation, or
- **Your disability earnings** if any, are less than [75-80%] of **your indexed monthly earnings**, and
- During the elimination period, you are unable to perform any of the **material and substantial duties** of your regular occupation, and you are not working in any occupation.]

[You are considered disabled when we review your claim and determine that, due to your sickness or injury, you are unable to perform the **material and substantial duties** of your regular occupation, and you are not working in any occupation.]

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

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

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

- You are continuously unable to perform two or more **activities of daily living** (ADLs), without **stand-by help.**
- You have a **cognitive impairment.**
- You have a **terminal illness.**]

[Throughout the **maximum period of payment**, if you are employed as a pilot, co-pilot or crew of an aircraft, you are considered disabled when we review your claim and determine that, due to your sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably qualified based on your training, education and experience.]

[Throughout the **maximum period of payment**, if you are employed as a pilot, co-pilot or crew of an aircraft, you are considered disabled when we review your claim and determine that, due to your sickness or injury, both of the following are true:

- You are unable to perform the duties of any **gainful occupation** for which you are reasonably qualified based on your training, education and experience.
- During the elimination period, you are unable to perform the duties of any **gainful occupation** for which you are reasonably qualified based on your education, training and experience, and you are not working in any occupation.]

## LONG TERM DISABILITY BENEFIT INFORMATION

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

**You** must be under the **appropriate care** of a **doctor** in order to be considered disabled.

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

### [ELIMINATION PERIOD

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

[For an elimination period more than 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 30 days or less.]

[For an elimination period of 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 14 days or less.]

[For an elimination period of 31 to less than 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 7 days or less for each 31 days of the elimination period.]

[If **your** elimination period is less than 31 days, and **your** disability stops during the elimination period, **we** will not consider **your** disability to be continuous.]

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

The elimination period begins on the first day of **your** disability.

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

### [ACCUMULATION OF ELIMINATION PERIOD

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

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

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

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

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

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

### [SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If **you** are working while **you** are disabled, the days **you** are disabled will count toward **your** elimination period.]

### WHEN YOU RECEIVE PAYMENTS

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

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

# LONG TERM DISABILITY BENEFIT INFORMATION

## AMOUNT OF PAYMENT

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

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

1. Multiply **your monthly earnings** by [25-80%].
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Subtract from **your gross monthly payment** any **deductible sources of income**.

The amount figured in Step 4 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

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

1. Multiply **your monthly earnings** by **your** elected and approved monthly benefit percentage.
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Subtract from **your gross monthly payment** any **deductible sources of income**.

The amount figured in Step 4 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

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

1. Multiply **your monthly earnings** by [25-80%].
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Multiply **your monthly earnings** by [50-100%] and subtract any **deductible sources of income** except income from any form of employment.
5. Compare the answers from Step 3 and Step 4.

The lesser amount in Step 5 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

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

1. Multiply **your monthly earnings** by **your** elected and approved monthly benefit percentage.
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Multiply **your monthly earnings** by [50-100%] and subtract any **deductible sources of income** except income from any form of employment.
5. Compare the answers from Step 3 and Step 4.

The lesser amount in Step 5 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

[**Your monthly payment** will be the monthly benefit as shown in the BENEFITS AT A GLANCE, [minus **deductible sources of income**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision].]

[**Your monthly payment** will be **your** elected and approved monthly benefit amount, [minus **deductible sources of income**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision].]

## LONG TERM DISABILITY BENEFIT INFORMATION

**[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO [75-80%] OF YOUR INDEXED MONTHLY EARNINGS]**

**[B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% OF YOUR INDEXED MONTHLY EARNINGS]**

[[During the first [12-24] months of payments, the] [The] sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings**. If the sum exceeds 100% of **your indexed monthly earnings**, we will reduce **your** payment under the policy by the excess amount.

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

1. Multiply **your monthly earnings** by [25-80%].
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Add **your disability earnings** to **your gross monthly payment**.]

1. Multiply **your monthly earnings** by **your** elected and approved monthly benefit percentage.
2. The **maximum benefit** is [\$500-40,000] per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment**.
4. Add **your disability earnings** to **your gross monthly payment**.]

1. **Your** monthly benefit as shown in the BENEFITS AT A GLANCE is equal to **your gross monthly payment**.
2. Add **your disability earnings** to **your gross monthly payment**.]

1. **Your** elected and approved monthly benefit amount is equal to **your gross monthly payment**.
2. Add **your disability earnings** to **your gross monthly payment**.]

[If the answer in Step [2] [4] above is less than or equal to 100% of **your indexed monthly earnings**, **your monthly payment** will be **your gross monthly payment** [minus any **deductible sources of income**]. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

[If the answer in Step [2] [4] above is greater than 100% of **your indexed monthly earnings**, we will follow this process to figure **your monthly payment**:

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

The amount figured in Step c is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

[[After [12-24] months of **monthly payments**, **you**] [**You**] will receive payments based on the percentage of income **you** are losing due to **your** disability. **We** will follow this process to determine **your monthly payment**:

1. Subtract **your disability earnings** from **your indexed monthly earnings**.
2. Divide the answer in Step 1 by **your indexed monthly earnings**. The result is **your** percentage of lost earnings.
3. From **your gross monthly payment**, subtract any **deductible sources of income**.
4. Multiply the answer in Step 2 by the answer in Step 3.

The answer in Step 4 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

## LONG TERM DISABILITY BENEFIT INFORMATION

[[After [12-24] months of payments, **your** **[Your] monthly payment** will be reduced by 50% of **your disability earnings**. We will follow this process to determine **your monthly payment**:

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

The answer in Step 2 is **your monthly payment**. If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.]

### **[C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN [75-80%] OF YOUR INDEXED MONTHLY EARNINGS**

If **you** are working and **your disability earnings** are more than [75-80%] of **your indexed monthly earnings**, no benefit will be payable.]

**[Your monthly payment** is the monthly benefit stated in the BENEFITS AT A GLANCE. [After 12 months of payments, **your monthly payment** will be reduced to 50% of the monthly benefit.]

**Your monthly payment** will not be reduced by any other disability benefits **you** receive.]

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

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

### **[IF YOUR DISABILITY EARNINGS FLUCTUATE**

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

If **we** average **your disability earnings**, **we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months exceeds [75-80%] of **your indexed monthly earnings**.

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

### **[WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS**

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings** [unless an excess amount is payable as a result of a Cost of Living Adjustment]. [However, if **you** are participating in a **vocational rehabilitation plan**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings** [unless an excess amount is payable as a result of a Cost of Living Adjustment].]

### **[COST OF LIVING ADJUSTMENT**

**We** will make a Cost of Living Adjustment (COLA) after **you** have received one full year of **monthly payments**.

**[Your** payment will increase by [.5-10%] of **your [gross] monthly payment** beginning on the first anniversary of payments and each following anniversary [not to exceed [5-10] anniversary adjustment periods] while **you** continue to receive payments for **your** disability.]

**[Your** payment will increase by the lesser of the following:

- [50-100%] of the increase in the CPI-U during the prior calendar year.
- [.5-10%] of **your [gross] monthly payment**.

The increase will begin on the first anniversary of payments and each following anniversary [not to exceed [5-10] anniversary adjustment periods] while **you** continue to receive payments for **your** disability.]

Each month, **we** will add the Cost of Living Adjustment to **your monthly payment**. When **we** add the adjustment to **your** payment, the increase may cause **your** payment to exceed the **maximum benefit**.

[Compounding will continue up to the maximum number of adjustments.]]

## LONG TERM DISABILITY BENEFIT INFORMATION

### [DEDUCTIBLE SOURCES OF INCOME

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

- The amount that **you** receive, or are eligible to receive, as disability income payments under any:
  - State compulsory benefit **act** or **law**.  
[– Individual disability income plans which are wholly or partially paid for by the **Policyholder** [or **your Employer**,] [or for which the **Policyholder** [or **your Employer**] makes payroll deductions,] and which are purchased on or after the effective date of the group policy.]
  - Automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable.
  - Military disability benefit plan.
  - Governmental retirement system as a result of **your** job with **your Employer**.
  - Other group insurance policy.
- The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones **Act**).
- The amount **you** receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
- The amount **you** receive under any **salary continuation or accumulated sick leave** plan. [For a paid time off plan, **we** will count only the amount **you** receive in excess of [16-80 hours] for each period of disability.]]
- The amount that **you**:
  - receive as disability payments under **your Employer's retirement plan**;
  - voluntarily elect to receive as retirement payments under **your Employer's retirement plan**; or
  - are eligible to receive as retirement payments when **you** reach the later of age 62 or normal retirement age, as defined in **your Employer's retirement plan**.

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

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

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

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

- The amount that **you**, **your** spouse and **your** children receive, or are eligible to receive, as disability payments because of **your** disability under:]
- The amount that **you** receive or are eligible to receive as disability payments under:]
  - The United States Social Security **Act**.
  - The Canada Pension **Plan**.
  - The Quebec Pension **Plan**.
  - Any similar **Plan** or **Act**.
- [**We** will not offset with any amount received by **your** spouse or dependents.]
- The amount that **you** receive as retirement payments or the amount **your** spouse and **your** children receive as retirement payments because **you** are receiving retirement payments under:]
- The amount that **you** receive as retirement payments under:]
  - The United States Social Security **Act**.
  - The Canada Pension **Plan**.
  - The Quebec Pension **Plan**.
  - Any similar **Plan** or **Act**.
- [**We** will not offset with any amount received by **your** spouse or dependents.]

## LONG TERM DISABILITY BENEFIT INFORMATION

- [• The amount **you** receive from any form of employment.]
- [• The amount **you** receive from any unemployment compensation **law**.]
- [• The amount that **you** receive, or are eligible to receive, under:
  - A workers' compensation **law**.
  - An occupational disease **law**.
  - Any other **act** or **law** with similar intent.]

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

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

[If **you** begin to receive or are eligible to receive a Social Security payment while **you** are eligible to receive payments under the policy, **we** will not reduce **your** monthly benefit under the policy by the amount of the first monthly Social Security payment **you** receive or are eligible to receive. Thereafter, **your** monthly benefit under the policy will be reduced by any monthly Social Security payments **you** receive or are eligible to receive.]]

### [**COST OF LIVING INCREASES FOR DEDUCTIBLE SOURCES OF INCOME**

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

### [**IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME**

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

- Not been awarded or denied.
- Been denied and the denial is being appealed.

**Your gross monthly payment** will NOT be reduced by the estimated amount if both of the following are true:

- **You** apply for the disability payments for which **you** are eligible in the **deductible sources of income** provision and appeal **your** denial to all administrative levels **we** determine are necessary.
- **You** sign **our** form. This form states that **you** promise to pay **us** any overpayment caused by an award and **we** shall be entitled to impose a constructive trust on any such award.

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

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

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

## LONG TERM DISABILITY BENEFIT INFORMATION

### [NON-DEDUCTIBLE SOURCES OF INCOME

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

- 401(k) plans.
- **Salary continuation or accumulated sick leave plans.**
- Up to [16-80 hours] for paid-time off under **salary continuation or accumulated sick leave plans** during a period of disability.]
- Profit sharing plans.
- Thrift plans.
- Tax-sheltered annuities.
- Stock ownership plans.
- Credit disability insurance.
- Non-qualified plans of deferred compensation.
- Pension plans for partners.
- Military pension plans.
- Franchise disability income plans.
- Individual disability plans paid for by the **insured person** [and not through payroll deduction].
- A retirement plan from another employer.
- Individual retirement accounts (IRA).

[If **salary continuation or accumulated sick leave** plan payments plus the **gross monthly payment** and **disability earnings** exceed 100% of **your monthly earnings**, we will subtract the amount in excess of 100% from **your monthly payment.**]

### [MINIMUM PAYMENT

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

- [\$50-250].
- [5-30%] of **your gross monthly payment.**]

[The minimum payment each month for a **payable claim** is [\$50-250].]

We may apply this amount to recover any outstanding overpayment.]

### [DURATION OF PAYMENTS

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

### [WHEN PAYMENTS END

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

- The end of the **maximum period of payment**.
- The date **you** are no longer disabled under the terms of the policy.
- The date **you** fail to submit proof of continuing disability.
- The date **you** die.
- During the **regular occupation period** when **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not.]
- After the **regular occupation period**, when **you** are able to work in any **gainful occupation** on a **part-time basis** but **you** do not.]
- When **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not.]
- The date **your disability earnings** exceed [75-80%] of **your indexed monthly earnings.**]
- The date **you** refuse to participate in **your vocational rehabilitation plan.**]
- After 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.]

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

# LONG TERM DISABILITY BENEFIT INFORMATION

## [PURSUING SOCIAL SECURITY DISABILITY INSURANCE (SSDI) BENEFITS

If:

- **You** are disabled according to the terms of the policy,
  - **You** are not receiving SSDI benefits, and
  - **We** have a reasonable belief that **you** are entitled to SSDI benefits,
- then **we** will assist **you** in pursuing **your** claim for SSDI benefits, at **our** expense. If **you** pursue a claim for SSDI benefits without **our** assistance, **you** will be responsible for the expense.

**You** will receive a **monthly payment** under the policy up to the **maximum period of payment** if all of the following are true:

- **You** are eligible for a benefit under the policy.
- **We** have a reasonable belief that **you** are entitled to SSDI benefits.
- **You** are pursuing a claim for SSDI benefits, or **you** have received a denial of **your** claim for SSDI benefits after exhausting all available administrative appeals.

## RECEIVING SSDI BENEFITS

If **you** have submitted a claim to **us** or are receiving a **monthly payment** under the policy, **you** must notify **us** promptly if **you** begin to receive SSDI benefits.

If **you** are receiving SSDI benefits for the same disability for which **you** are claiming benefits under the policy, **you** are not eligible for benefits under the policy.

## DURATION OF PAYMENTS

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

## WHEN PAYMENTS END

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

- The end of the **maximum period of payment**.
- The date **you** are no longer disabled under the terms of the policy.
- The date **you** fail to submit proof of continuing disability.
- The date **you** die.
- The end of the month following the date **you** begin to receive SSDI benefits.
- The date **you** fail to pursue SSDI benefits with reasonable diligence, if **we** have determined that **you** may qualify for such benefits.
- After 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

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

# LONG TERM DISABILITY BENEFIT INFORMATION

## DISABILITIES NOT COVERED UNDER THE POLICY

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

- Loss of professional license, occupational license or certification.
  - Commission of or attempt to commit a felony.
  - Intentionally self-inflicted injuries.
  - Attempted suicide, regardless of mental capacity.
  - Being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor**.
  - Participation in a war, declared or undeclared, or any act of war.
  - Active military duty.
  - Active participation in a riot.
  - Engaging in any illegal or fraudulent occupation, work or employment.
  - Commission of a crime for which **you** have been convicted.
  - Elective surgery except when required for **your appropriate care** as a result of **your injury** or **sickness**.
  - Traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes.
- [• **Occupational sickness or injury.**]

## [PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if **your** disability begins in the first [3-24] months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a **pre-existing condition.**]

## [PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if **your** disability begins in the first [3-24] months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a **pre-existing condition**, unless **you** were **treatment free** for [3-12] consecutive months after **your** effective date of coverage.]

## [MENTAL ILLNESS LIMITATION

The [lifetime cumulative] **maximum period of payment** for all disabilities due to **mental illness** is [12-24] months. Only [12-24] months of benefits will be paid even if the disabilities are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the [12-24] month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the [12-24] month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

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

**We** will not apply the **mental illness** limitation to a disability due to dementia if it is a result of stroke, trauma, viral infection or Alzheimer's disease.]

## LONG TERM DISABILITY BENEFIT INFORMATION

### [ALCOHOLISM OR DRUG ABUSE LIMITATION

The [lifetime cumulative] **maximum period of payment** for all disabilities due to alcoholism or drug abuse is [12-24] months. Only [12-24] months of benefits will be paid even if the disabilities are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the [12-24] month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the [12-24] month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

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

### [MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The [lifetime cumulative] **maximum period of payment** for all disabilities due to **mental illness**, alcoholism or drug abuse is [12-24] months. Only [12-24] months of benefits will be paid [for any combination of such disabilities] even if the disabilities are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the [12-24] month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the [12-24] month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

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

**We** will not apply the **mental illness** limitation to a disability due to dementia if it is a result of stroke, trauma, viral infection or Alzheimer's disease.]

### [SPECIAL CONDITIONS LIMITATION

The [lifetime cumulative] **maximum period of payment** for all disabilities due to **special conditions** is [12-24] months. Only [12-24] months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the [12-24] month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the [12-24] month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

## LONG TERM DISABILITY BENEFIT INFORMATION

If **you** are disabled due to carpal tunnel syndrome or one or more herniated or ruptured disc(s) and the carpal tunnel syndrome or herniated or ruptured disc(s) require that a surgical procedure be performed by a **doctor**, then the **maximum period of payment** will be up to [12-24] months immediately following the most recent surgical procedure.

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

### [CONTINUITY OF COVERAGE

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

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

- The [end of the month following the] date **you** return to **active employment**.
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of **our** policy.

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

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

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

### [CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITIONS

**We** may pay benefits if **your** disability is caused by, contributed by or results from a **pre-existing condition** if both of the following are true:

- **You** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy.
- **You** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under either **our** policy or under the prior policy, if benefits would have been paid had that policy remained in force.

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

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

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

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

**We** will require proof that **you** were insured under the prior policy. All other provisions of **our** policy will apply.]

# LONG TERM DISABILITY BENEFIT INFORMATION

## RECURRENT DISABILITY

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

**Your monthly payment** will be based on **your monthly earnings** as of the date of **your** initial claim. **Your** disability, as outlined above, will be subject to the same terms of the policy as **your** prior claim.

**Your** disability will be treated as a new claim if either of the following is true:

- **Your** current disability is unrelated to **your** prior disability.
- After **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

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

If **our** policy terminates and **you** become eligible for coverage under any other group disability plan that replaces **our** policy, **you** will not be eligible for coverage under **our** policy.

## [VOCATIONAL REHABILITATION SERVICES

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

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

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

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

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

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

[**Your** failure to participate with **your** full cooperation in the **vocational rehabilitation plan**, without good cause, will result in the termination of **your** long term disability benefits. "Good cause" means a medical reason preventing implementation of the **vocational rehabilitation plan**. If **your** benefits terminate, **your** coverage under the policy will terminate.]]

## [VOCATIONAL REHABILITATION BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan**, **you** may be eligible for an additional Vocational Rehabilitation Benefit. **We** will pay an additional benefit of [5-15%] of **your gross monthly payment** to a maximum of [\$500-5,000] per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income**. However, the Total Benefit Cap will apply.

## LONG TERM DISABILITY BENEFIT INFORMATION

Vocational Rehabilitation Benefits will end on the earliest of the following dates:

- The date **we** determine that **you** are no longer eligible to participate in a **vocational rehabilitation plan**.
- The date **you** are no longer participating in a **vocational rehabilitation plan**.
- Any other date on which **monthly payments** would stop in accordance with the policy.]

### [[CHILD] [FAMILY MEMBER] CARE EXPENSE BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan**, **you** will be eligible for an additional **[Child] [Family Member] Care Expense Benefit** if **you** are incurring expenses to provide care for a **[child under age [13-15]] [family member]** who requires personal care assistance.

**We** will pay a **[Child] [Family Member] Care Expense Benefit** of [\$250-1,000] per **[child] [family member]** not to exceed a maximum of [\$1,000-5,000] per month.

The **[Child] [Family Member] Care Expense Benefit** will end on the earliest of the following dates:

- The date **you** are no longer incurring **[child] [family member] care expenses**.
- The date **you** are no longer participating in a **vocational rehabilitation plan**.
- After [12-36] months of **[Child] [Family Member] Care Expense Benefits** have been paid for each **[child] [family member]**.]
- Any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide satisfactory proof that **you** are incurring a **[child] [family member] care expense**.

**[Child] [Family member] care** means care or supervision of **your [child] [family member]** and care is given by a [licensed child-care center or a] licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income**. However, the Total Benefit Cap will apply.]

### [WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment under the policy from **us**, a Workplace Modification Benefit may be payable to **your Employer**. Subject to the maximum amount below, **we** will reimburse **your Employer** for 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

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

- [Two-Three] times **your** last **monthly payment**.
- [\$2,000-10,000].

**You** must meet both of the following requirements:

- Be disabled according to the terms of the policy.
- Have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

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

- Input from the **Employer, you** and **your doctor**.
- The purpose of the proposed workplace modification.
- The expected completion date of the workplace modification.
- The cost of the workplace modification.

**We** will reimburse the costs of the workplace modification when all of the following are true:

- **We** approve the proposal in writing.
- **We** receive proof from **your Employer** that the workplace modification is complete.
- **We** receive proof of the costs incurred by **your Employer** for the workplace modification.

The Workplace Modification Benefit is available on a one-time basis for each **insured person** under the policy.]

# LONG TERM DISABILITY BENEFIT INFORMATION

## [SURVIVOR BENEFIT

[When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to [three (3)-six (6)] times **your** [last full] **[gross] monthly payment** if, on the date of **your** death, both of the following are true:

- **Your** disability had continued for [30-180] or more consecutive days.
- **You** were receiving or were eligible to receive payments under the policy.]

[When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a benefit equal to [25-80%] of **your** [last full] **[gross] monthly payment** for [12-24] months if, on the date of **your** death both of the following are true:

- **Your** disability had continued for 12 or more consecutive months.
- **You** were receiving payments under the policy.]

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

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

## [ADVANCED SURVIVOR BENEFIT

**You** may receive an Advanced Survivor Benefit prior to **your** death if **you** have been diagnosed with a **terminal illness**.

**We** will pay **you** a lump sum amount equal to [3-6] times **your** [last full] **[gross] monthly payment** if both of the following are true:

- **Your** disability had continued for [30-180] or more consecutive days.
- **You** have been diagnosed with a **terminal illness**.

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

**Your** right to exercise this option and receive payment is subject to both of the following:

- **You** must make this election in writing to **us**.
- **Your doctor** must certify in writing that **you** have a **terminal illness**.

This benefit is available to **you** on a voluntary basis and will be payable only one time under the policy.

If **you** receive the Advanced Survivor Benefit prior to **your** death, the [3-6] month Survivor Benefit will not be payable upon **your** death.]

## [ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT

If an **accidental injury** occurs while **you** are insured under the policy, and results in any of the losses shown in the schedule below within [180-365] days after the date of the **injury**, then **we** will pay a **gross monthly payment** to **you** for the longer of:

- The number of payments listed on the schedule below.
- The number of months **you** remain disabled, not to exceed the **maximum period of payment**.

Payment of this benefit will not be subject to satisfying the elimination period. However, after the elimination period has been completed, this benefit will be paid instead of the regular **monthly payment**, not in addition to it. If **you** remain disabled beyond the number of monthly payments under this provision, benefits may continue as provided under the policy. The months **you** receive benefits under this provision will be excluded in computing the number of months **you** receive payments for disability and in computing any remaining **maximum period of payment** for disability. If **you** die, this benefit will cease.

# LONG TERM DISABILITY BENEFIT INFORMATION

## Monthly Payments for loss of:

## Schedule of Monthly Payments:

Sight of both eyes .....	46
Both hands .....	46
Both feet .....	46
One hand and one foot .....	46
One hand and sight of one eye .....	46
One foot and sight of one eye .....	46
One hand or one foot .....	23
Sight of one eye .....	15
Thumb and Index Finger of either hand .....	12

NOTE: The maximum number of **monthly payments** for all losses suffered from any one **accidental injury** will be limited to that one loss for which the greatest number of **monthly payments** is provided in the above schedule.

"Loss of hands and feet" means the loss by severance at or above the wrist or ankle joint.

"Loss of sight" means total and irrevocable loss of sight.

"Loss of thumb and index finger" means actual severance at or above the knuckles joining each to the hand.]

## [EDUCATION EXPENSE BENEFIT

If **you** are disabled and receiving **monthly payments** under the policy, **you** will receive a monthly Education Expense Benefit in the amount of [\$200-1,000] for each **eligible student**, limited to a combined monthly maximum of \$1,000. The Education Expense Benefit is in addition to **your monthly payment**.

Benefits will be payable in between school terms as long as **your eligible student** is enrolled for the next scheduled school term.

The Education Expense Benefit will end on the earlier of the following:

- The date **your** child is no longer an **eligible student**.
- Any other date the **monthly payments** would stop in accordance with the policy provisions.]

## [EXTENDED EARNINGS PROTECTION BENEFIT

**We** will send **you** a **monthly payment** if **you** have been disabled and all of the following are true:

- **You** have satisfied the elimination period for that disability.
- **You** return to **your regular occupation** or another occupation full-time with the **Employer** [or another employer] the day after **your** disability ends.
- **You** have a 20% or more loss in **your indexed monthly earnings** due to the same disability.
- [• **You** have received at least [3-24] **monthly payments** for that disability.]

The Extended Earnings Protection Benefit will be based on the percentage of income **you** have lost following **your** return to work and will be calculated as follows:

1. Subtract **your** current **monthly earnings** from **your indexed monthly earnings**.
2. Divide the answer in Step 1 by **your indexed monthly earnings**. The result is **your** percentage of lost earnings.
3. Multiply the answer in Step 2 by **your gross monthly payment**.

The answer in Step 3 is **your** Extended Earnings Protection Benefit.

The Extended Earnings Protection Benefit payment will end on the earlier of the following:

- The date the Extended Earnings Protection Benefit has been paid for [3-24] months.
- The date **your** current **monthly earnings** exceed [75-80%] of **your indexed monthly earnings**.]

## LONG TERM DISABILITY BENEFIT INFORMATION

### [PROGRESSIVE DISEASE BENEFIT

Once **you** become insured under the policy and if **you** are diagnosed with a **progressive disease**, **you** will be eligible for the **Progressive Disease** Benefit.

To be eligible for this benefit, **you** must provide **us** with proof that **you** have been diagnosed with a **progressive disease**.

If **you** become disabled from a **progressive disease** and become eligible for benefits under the policy, the **monthly earnings** used to determine **your monthly payment** will be the greater of the following:

- **Your monthly earnings** at the time **you** provided **us** with satisfactory proof of **your progressive disease**.
- **Your monthly earnings** at the time **you** become disabled under the policy.

The premium for **your** coverage under the policy will be based on the **monthly earnings** used to determine **your monthly payment**, unless **you** qualify for waiver of premium under the terms of the policy.]

### [RETIREMENT INCOME CONTRIBUTION BENEFIT

If **you** are disabled and qualify for a **monthly payment** from **us** and have participated in **your Employer's** [401(k)] [403(b)] [457] [pension] plan for at least 3 months before **you** became disabled, then **you** may be eligible to receive an additional benefit.

This additional benefit will equal the amount **you** were contributing toward **your Employer's** [401(k)] [403(b)] [457] [pension] plan as of the date of **your** disability, but will not be more than [1-15%] of **your monthly earnings**, and will not exceed the maximum allowable by **law**.

If **you** are disabled and working and earning between 20% through [75-80%] of **your monthly earnings**, the benefit will be based on the percentage of income **you** are losing due to **your** disability according to the following steps:

1. Subtract **your disability earnings** from **your monthly earnings**.
2. Divide the answer in Step 1 by **your monthly earnings**. This is **your** percentage of lost earnings.
3. Multiply **your** additional benefit by the percentage of lost earnings determined in Step 2.

**We** will pay this additional benefit to the **Employer** for deposit into **your Employer's** [401(k)] [403(b)] [457] [pension] plan on **your** behalf. If **your Employer's** [401(k)] [403(b)] [457] [pension] plan cannot accept the additional benefit, **you** may have an alternative retirement savings plan, such as a flexible premium deferred annuity, established and maintained by **you** to receive the additional benefit.

**We** will stop paying this benefit on the earliest of the following:

- The date **you** are no longer disabled under the terms of the policy.
- The date **you** stop participating in the **Employer's** [401(k)] [403(b)] [457] [pension] plan.
- The date **you** do not have a retirement savings plan in effect that can accept the additional benefit.
- The date **you** stop receiving disability payments from **us** under the policy.]

### [SUPPLEMENTAL DISABILITY BENEFIT

**We** will pay **you** an additional supplemental disability benefit equal to [10-40%] of **your monthly earnings**, not to exceed [\$1,000-5,000] per month, if **you** are unable to perform the **material and substantial duties** of **your regular occupation** due to **your sickness** or **injury**, and one of the following is also true:

- **You** are continuously unable to perform two or more **activities of daily living** (ADL), without **stand-by help**.
- **You** have a **cognitive impairment**.
- **You** have a **terminal illness**.]

## LONG TERM DISABILITY BENEFIT INFORMATION

### [RETROACTIVE BENEFIT

If **you** are receiving or entitled to receive a monthly benefit due to **your** disability, **we** will pay a Retroactive Benefit if all of the following are true:

- **You** have satisfied the elimination period.
- **You** are unable to perform the **material and substantial duties** of **your regular occupation** due to **your sickness or injury**.
- **You** are not working due to **your** disability, and **you** were continuously not working during **your** elimination period due to **your** disability.
- **You** were **hospital confined** for 14 consecutive days or more starting within 48 hours of the day **your** disability began.

The Retroactive Benefit is payable in a lump sum and will equal  $\frac{1}{30}$ th of **your gross monthly payment** for each day **you** were disabled during **your** elimination period. [This benefit will be paid only once during **your** lifetime.]

## INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT INFORMATION

The **Infectious and Contagious Disease** Benefit is subject to all provisions of the policy other than as stated in this section.

For purposes of determining **your** coverage and eligibility for **Infectious and Contagious Disease** Benefits, both of the following apply:

- The terms "disability" and "disabled" as used in the policy will mean **impairment** and **impaired** as used in this section.
- Receiving an **Infectious and Contagious Disease** Benefit will be treated as receiving a **monthly payment** for disability under the policy.

### ELIGIBILITY

**You** are eligible for the **Infectious and Contagious Disease** Benefit if either of these is true:

- **You** initially test positive for an **infectious and contagious disease** on or after **your** effective date of coverage under the policy.
- **You** initially test positive for an **infectious and contagious disease** on or after the effective date of **your** coverage under a prior policy and are not **impaired** on the effective date of **your** coverage under **our** policy. The meaning of prior policy is as described in the CONTINUITY OF COVERAGE provision.

### WHEN YOU RECEIVE PAYMENTS

**You** will begin to receive payments when **we** approve **your** claim, provided **you** have completed the elimination period and **you** are **impaired** as a result of an **infectious and contagious disease**.

In order to satisfy the elimination period under this provision, **you** must have a 20% or more loss in **your monthly earnings** due to **your impairment** during the elimination period.

### AMOUNT OF INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT PAYMENT

**We** will determine **your Infectious and Contagious Disease** Benefit payment amount as shown in the AMOUNT OF PAYMENT provision.

The **Infectious and Contagious Disease** Benefit will be paid instead of the regular **monthly payment** under the policy, not in addition to it.

### DURATION OF PAYMENTS

[The **Infectious and Contagious Disease** Benefit **maximum period of payment** is [12-60 months].]

[The **Infectious and Contagious Disease** Benefit **maximum period of payment** is the **maximum period of payment** reflected in the BENEFITS AT A GLANCE.] **We** will send **you** a payment each month up to the **maximum period of payment**. [This is the lifetime cumulative **maximum period of payment** for any combination of **infectious and contagious diseases** even if they are continuous and/or are not related.]

The **Infectious and Contagious Disease** Benefit will end on the earliest of the following dates:

- The date **you** no longer test positive for an **infectious and contagious disease**.
- The date the disease for which **you** tested positive is no longer an **infectious and contagious disease**.
- The date **you** are no longer **impaired** as that term is used in this section.
- The end of the **maximum period of payment** for the **Infectious and Contagious Disease** Benefit.
- The date **your monthly benefit** for disability would have ended if **you** had been disabled instead of **impaired**.
- After 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.
- The date **your monthly disability earnings** exceed 80% of **your monthly earnings**.
- The date **you** die.

## INFECTIOUS AND CONTAGIOUS DISEASE BENEFIT INFORMATION

[If **Infectious and Contagious Disease** Benefits end, the **monthly payment** for a disability may be paid if **you** are disabled under the terms of the policy. If **you** are entitled to a **monthly payment** for disability immediately following the date **your Infectious and Contagious Disease** Benefits end, **you** will not have to satisfy a new elimination period to receive a **monthly payment** for disability. **Your** receipt of an **Infectious and Contagious Disease** Benefit will count as **your** having received a **monthly payment** for disability and will be subtracted from the **maximum period of payment** for disability, if applicable.]

### EXCLUSIONS AND LIMITATIONS

All of the exclusions under the DISABILITIES NOT COVERED UNDER THE POLICY provision apply to this **Infectious and Contagious Disease** Benefit except that loss of a professional license, occupational license or certification can be a contributing cause of **your impairment**.

This **Infectious and Contagious Disease** Benefit provision is subject to the PRE-EXISTING CONDITION LIMITATION provision.

The CONTINUITY OF COVERAGE provision will apply to this **Infectious and Contagious Disease** Benefit so long as **you** were insured for a similar benefit under **your** prior policy.]

## [MEDICAL OR COBRA PREMIUM DISABILITY BENEFIT INFORMATION

If **you** are disabled and receiving a **monthly payment** for disability under the policy, **you** may be eligible to receive an additional Medical or **COBRA** Premium Disability Benefit. This benefit is subject to all provisions of the policy other than as stated in this section.

### ELIGIBILITY

**You** are eligible for the Medical or **COBRA** Premium Disability Benefit if all of the following are true:

- **You** are insured under the policy.
- **You** are disabled according to the terms of the policy.
- **You** are receiving or are eligible to receive a **monthly payment** for disability under the policy.
- **You** are paying premiums for **medical coverage** or **COBRA Medical Coverage** under **your Employer's** plan.

Benefits for a **payable claim** begin the day after **you** satisfy all of the requirements above.

### AMOUNT OF MEDICAL OR COBRA PREMIUM DISABILITY BENEFIT PAYMENT

**We** will pay **you** an additional disability benefit per month, equal to the lesser of the following:

- The amount of the monthly premium **you** are paying for yourself only, for **medical coverage** or **COBRA Medical Coverage**.
- [\$300-1,000].

**Your** Medical or **COBRA** Premium Disability Benefit will not be reduced by any **deductible sources of income** listed in the certificate.

If **you** are eligible to receive a Medical or **COBRA** Premium Disability Benefit for less than 1 month, **we** will send **you** 1/30th of **your** payment for each day **you** are disabled.

### DURATION OF BENEFIT PAYMENTS

The Medical or **COBRA** Premium Disability Benefit payments will end on the earliest of the following:

- The date **you** are no longer receiving or are no longer eligible to receive a **monthly payment** for disability under the policy.
- The date **you** are no longer disabled under the terms of the policy.
- The date **you** have received [18-39] months of Medical or **COBRA** Premium Disability Benefit payments, for a combination of **medical coverage** and **COBRA Medical Coverage**.
- The last day **you** are covered for **medical coverage** or **COBRA Medical Coverage**.
- The last day of the period for which **you** qualify for **COBRA Medical Coverage**.
- The date **you** fail to give **us** the required proof that **you** are paying premiums for **medical coverage** or **COBRA Medical Coverage**.

### EXCLUSIONS AND LIMITATIONS

All exclusions and limitations under the DISABILITIES NOT COVERED UNDER THE POLICY provision apply to the Medical or **COBRA** Premium Disability Benefit.

### CLAIMS

The CLAIM INFORMATION section applies to the Medical or **COBRA** Premium Disability Benefit. **You** must also submit proof, in a form acceptable to **us**, of **your medical coverage** or **COBRA Medical Coverage** premiums that **you** have paid for yourself.

**We** may apply the Medical and **COBRA** Premium Disability Benefit to recover any overpayment that may exist on **your** claim.]

# CLAIM INFORMATION

## NOTICE OF CLAIM

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

The claim form is available from [the **Policyholder**] [**your Employer**] or **you** can request a claim form from **us**. If **you** do not receive the form from **us** within 15 days of **your** request, send **us** written proof of claim without waiting for the form.

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

## FILING A CLAIM

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

## PROOF OF YOUR CLAIM

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

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

- That **you** are under the **appropriate care** of a **doctor**.
- The date **your** disability began.
- The cause of **your** disability.
- The appropriate documentation of **your** earnings and **your** activities.
- The extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation**.
- The name and address of any **hospital, health facility or institution** where **you** received treatment, including all attending **doctors**.
- Documentation of prior disability coverage, if applicable.

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

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

## MAKING PAYMENTS

Once **your** claim has been approved, **we** will send **you** a payment at the end of each month for any period for which **we** are liable. Any balance remaining unpaid at the termination of a period of disability will be paid immediately upon receipt of **your** proof of claim.

## OVERPAID CLAIMS

**We** have the right to recover any overpayments due to any of the following:

- Fraud.
- Any administrative error **we** make in processing a claim.
- [• **Your** receipt of **deductible sources of income**.]
- [• **Your** failure to notify **us** promptly of **your** receipt of SSDI benefits.]

**You** must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **We** will not recover more money than the amount **we** paid **you**. However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

## CLAIM INFORMATION

### CONSUMER NOTICE

The nearest servicing office is the Minneapolis, Minnesota office of ING Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.

The mailing address is:

P.O. Box 20

Minneapolis, Minnesota 55440-0122

Telephone: [(800) 537-5024]

If **you** are not provided reasonable and adequate service, **you** should feel free to contact:

Arkansas Insurance Department

[Consumer Services Division

1200 West Third Street

(Corner of Third and Cross Street)

Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640

Toll Free: (800) 852-5494]



RELIASTAR LIFE INSURANCE COMPANY  
**POLICY AMENDMENT NUMBER [1]**

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]

The policy above has been changed as follows. Please attach this amendment to the policy. This amendment is subject to all other terms of the policy.

[The following [is] [are] **added** under **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED:]** **[PARTICIPATING EMPLOYERS:]**

NAME	LOCATION (CITY AND STATE)
[DEF Company]	[Seattle, Washington]

[The following [is] [are] **deleted** under **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED:]** **[PARTICIPATING EMPLOYERS:]**

NAME	LOCATION (CITY AND STATE)
[XYZ Company]	[Columbus, Ohio]

**EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after [January 1, 2012].

A handwritten signature in cursive script that reads "Jay M. Benner".

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
**POLICY AMENDMENT NUMBER [2]**

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]

The policy above has been changed as follows. Please attach this amendment to the policy. This amendment is subject to all other terms of the policy.

**I. PART B. INSURED PERSONS' BENEFITS SECTION**

The [Certificate Index] [and] [Endorsement/Amendment/Rider Index] [is] [are] revised:

[Certificate B-6666 is added.  
Certificate B-3333 is deleted.  
Certificate B-4444a replaces B-4444.  
Endorsement R-88888 is added.  
Endorsement R-12121 is deleted.  
Endorsement R-21212a replaces R-21212.  
Amendment RB-11111 is added.  
Amendment RB-22222 is deleted.  
Amendment RB-33333a replaces RB-33333.  
Rider RB-99999 is added.  
Rider RB-88888 is deleted.  
Rider RB-77777a replaces RB-77777.]

The attached PART B. INSURED PERSONS' SECTION page of the policy replaces the previous version.

**II. EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after [September 1, 2012].

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
POLICY AMENDMENT NUMBER [3]

POLICYHOLDER: [ABC Company]  
GROUP POLICY NUMBER: [12345-6LTD]

The policy above has been changed as follows. Please attach this amendment to the policy. This amendment is subject to all other terms of the policy.

### [I. BUSINESS PROTECTION BENEFIT

The BUSINESS PROTECTION BENEFIT is [added to] [deleted from] the policy.

#### [BUSINESS PROTECTION BENEFIT

A monthly Business Protection Benefit will be paid to the **Employer** to compensate for business revenue lost as a result of an **insured person's** disability if that **insured person** is receiving a **monthly payment** under the policy, and is one of the following:

- A sole proprietor of the **Employer** if the **Employer** is a sole proprietorship.
- A general partner of the **Employer** if the **Employer** is a partnership.
- A member of a limited liability company if the **Employer** is a limited liability company.

The elimination period for the Business Protection Benefit is the greater of the following:

- The elimination period for the **insured person's** Long Term Disability benefits under the policy.
- 90 consecutive days.

The amount of the Business Protection Benefit payment is the **monthly payment** the **insured person** is receiving under the policy; however, the Business Protection Benefit will not be reduced by **deductible sources of income**.

The Business Protection Benefit will end on the earliest of the following:

- The date the **insured person** is no longer disabled.
- The date the **insured person** ceases to be a sole proprietor, general partner, or member of a limited liability company.
- The date the Business Protection Benefit has been paid for [3-60] months.

[The PRE-EXISTING LIMITATION provision of the policy applies to this Business Protection Benefit, as of the effective date of the Business Protection Benefit coverage for each **insured person**.]

[In order for the policy to include a Business Protection Benefit for an **insured person**, that person must submit an **evidence of insurability** form to **us** for approval. The Business Protection Benefit coverage for that person will become effective on the later of the following:

- The date the Business Protection Benefit has been added to the policy.
- The date **we** approve the Business Protection Benefit coverage for that person.]]]

### [[II.] TEMPORARY WORK BENEFIT

The TEMPORARY WORK BENEFIT is [added to] [deleted from] the policy.

#### [TEMPORARY WORK BENEFIT

**We** will pay the **Employer** a one-time benefit of \$1,000 to be used to supplement the cost of a temporary worker when an **insured person** under the policy is disabled and receiving disability benefits from **us**.

The **Employer** qualifies for this Temporary Work Benefit when all of the following are true:

- An **insured person** is disabled according to the terms of the policy.
- The **insured person** has satisfied the elimination period for the policy.
- The **insured person's** claim is approved and the **insured person** is receiving disability benefits under the policy.

This one-time payment will be made to the **Employer** no later than 90 days following the date the first disabled **insured person** under the policy receives his or her first Long Term Disability payment under the policy.

The Temporary Work Benefit is paid only once while the policy is in force, including any renewals.]]

**[III.] EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after [January 1, 2012].

A handwritten signature in cursive script that reads "Jay M. Benner".

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
**POLICY AMENDMENT NUMBER [4]**

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]

The policy above has been changed as follows. Please attach this amendment to the policy. This amendment is subject to all other terms of the policy.

**I. POLICYHOLDER**

The legal name of the **Policyholder** is changed from [ABC Company] to [PDQ Corporation].

**II. EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after [January 1, 2013].

A handwritten signature in cursive script that reads "Jay M. Benner".

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
POLICY AMENDMENT NUMBER [5]

POLICYHOLDER: [ABC Company]  
GROUP POLICY NUMBER: [12345-6LTD]

The policy above has been changed as follows. Please attach this amendment to the policy. This amendment is subject to all other terms of the policy.

**I. [PROVISION NAME]**

*[(only text approved within the policy form submission will be used here)]*

**[[II.] [PROVISION NAME]**

*[(only text approved within the policy form submission will be used here)]]*

**[III.] EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after [June 1, 2011].

A handwritten signature in cursive script that reads "Jay M. Benner".

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
**CERTIFICATE AMENDMENT**

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]  
**[EMPLOYER: [XYZ Company]]**  
**[(Applicable only to Class II)]**

**Your** certificate [B-4444] has been changed as follows. Please keep this amendment with **your** certificate. This amendment is subject to all other terms of the policy/certificate.

**I. MONTHLY BENEFIT**

The amount of the **maximum benefit** is changed to [\$500-40,000] per month.

[The **maximum benefit** amount in excess of [\$500-40,000] is subject to the PRE-EXISTING CONDITIONS LIMITATION provision as of the effective date of this amendment.]

**II. EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after the later of the following dates:

- [January 1, 2012].
- The effective date of **your** insurance.

Secretary



RELIASTAR LIFE INSURANCE COMPANY  
**CERTIFICATE AMENDMENT**

**POLICYHOLDER:** [ABC Company]  
**GROUP POLICY NUMBER:** [12345-6LTD]  
**[EMPLOYER: [XYZ Company]]**  
**[(Applicable only to Class I)]**

**Your** certificate [B-4444] has been changed as follows. Please keep this amendment with **your** certificate. This amendment is subject to all other terms of the policy/certificate.

**I. [PROVISION NAME]**

*[(only text approved within the policy/certificate form submission will be used here)]*

**[[II.] [PROVISION NAME]**

*[(only text approved within the policy/certificate form submission will be used here)]]*

**[III.] EFFECTIVE DATE**

This amendment is effective for disabilities which start on or after the later of the following dates:

- [June 1, 2011].
- The effective date of **your** insurance.

Secretary

## Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of ING Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.

The mailing address is:

PO Box 20  
Minneapolis, Minnesota 55440-0122  
Telephone: (800) 537-5024

If you are not provided with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
(Corner of Third and Cross Street)  
Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640  
Toll Free in AR: (800) 852-5494

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

<i>SERFF Tracking Number:</i>	<i>MNNP-126931276</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>ReliaStar Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47603</i>
<i>Company Tracking Number:</i>	<i>HP13GP</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.003 Long Term</i>
<i>Product Name:</i>	<i>LTD 2011</i>		
<i>Project Name/Number:</i>	<i>LTD 2011/</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	01/06/2011
<b>Comments:</b>		
<b>Attachment:</b> ar_readabilitycert.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	01/06/2011
<b>Comments:</b> Group Application form GrpAppStnd was approved for use with our group life and health products on August 6, 2003.  Evidence of Insurability form 47228 was approved for use with our group life and disability income products on November 9, 2001.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	01/06/2011
<b>Comments:</b>		
<b>Attachment:</b> ar_ltdvariables.pdf		

ReliaStar Life Insurance Company  
Minneapolis, Minnesota

**ARKANSAS READABILITY CERTIFICATION**  
Arkansas Statutes, Title 23, Chapter 80, Subchapter 2  
Life and Disability Insurance Policy Language Simplification Act

ReliaStar Life Insurance Company hereby certifies that forms HP13GP, et al have achieved a Flesch Reading Ease Score of more than 40 and comply with the requirements of the Life and Disability Insurance Policy Language Simplification Act.



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Susannah Saver-Patterson  
Assistant Secretary

December 29, 2010  
Date

ReliaStar Life Insurance Company  
Minneapolis, Minnesota

**ARKANSAS  
STATEMENT OF VARIABILITY  
for Long Term Disability Income**

Group Disability Income Policy form HP13GP  
Group Disability Income Certificate form HC13GPAR  
Group Policy Amendment forms LTD-PA1, LTD-PA2, LTD-PA3, LTD-PA4 and LTD-PA5  
Group Certificate Amendment forms LTD-CA1 and LTD-CA2

Bracketed text may be included or removed. The policy and certificate forms include multiple versions of some provisions in order to provide multiple options to the group policyholder.

When bracketed text is deleted, paragraphs and page numbering may be shifted.

Bracketed numbers indicate the range that will be used for those numbers.

Within numbered lists, the removal of an item or items from the list will cause the numbering to be adjusted.

All officer signatures may be changed in the future.

Other specific variables are defined in more detail below.

**LTD POLICY**

Cover Page – Policyholder, Group Policy Number, Policy Effective Date, Policy Anniversary Date: All policy and policyholder data will be case-specific.

Table of Contents (page 2): Page numbering will be adjusted as needed.

Part A. Policyholder Provisions – Cost of Insurance (pages 3-4): Rates and effective dates will be case-specific. References to “Basic Benefit” and “Buy-Up Benefit(s)” if used may be changed to some other label describing the different benefit selections, such as “Core” and “Additional” or “Option 1” and “Option 2.” Additional rows or tables may be added if there are more benefit levels available.

Part A. Policyholder Provisions – Initial Rate Guarantee and Rate Changes, and When Premium is Due (page 4): References to dates will be case-specific.

Part A. Policyholder Provisions – Divisions, Subsidiaries or Affiliated Companies Included / Participating Employers (page 7): The names and locations listed will be case-specific.

Part B. Insured Persons’ Benefits Section (page 9): The policyholder data for Policyholder, Group Policy Number, classes, certificate numbers, amendment/endorsement/ rider numbers and effective dates will be case-specific. The data in the right footer, if used, will be case-specific.

## LTD CERTIFICATE

The data in the right footer of all pages, if used, will be case-specific.

Cover Page – Policyholder, Group Policy Number, Policy Effective Date, Employer, Employer Plan Effective Date: All policy, policyholder and employer data will be case-specific.

Cover Page: The cover page may need to include, underneath the Registrar signature line, state-specific notices required by other states when a policy issued in Arkansas covers residents of those other states.

Table of Contents (page 2): Page numbering will be adjusted as needed.

Benefits at a Glance – Employer, Group Policy Number, Account Number (page 3): All policy and employer data will be case-specific.

Benefits at a Glance – Eligible Class(es) (page 3): The reference to “All employees” will be case-specific to describe the eligible classes under the plan, subject to state law. Reference to Employer locations in other countries, if used, will specify the countries. Reference to “an employee” may be changed to match the defined term used (e.g. a member, an associate).

Benefits at a Glance – Minimum Hours Requirement (page 3): This description will be case-specific to support various group eligibility requirements.

Benefits at a Glance – Rehire (page 3): The reference to 1-12 months may be instead represented as days (30-365 days).

Benefits at a Glance – Who Pays for the Coverage (2<sup>nd</sup> version on page 3): References to “Option 1” and “Option 2” if used may be changed to some other label describing the different benefit selections, such as “Base” and “Buy-Up.” The second row may refer to multiple options, such as “Options 2, 3 and 4.”

Benefits at a Glance – Elimination Period (page 4): The reference to 2-10 days if used may be instead represented as hours (16-80 hours). The references to “Option A” and “Option B” if used may be changed to some other label describing the different options such as “Plan 1” and “Plan 2.” Additional rows may be added if needed for multiple options.

Benefits at a Glance – Monthly Benefit (page 4): This description will be case-specific to support the appropriate calculation method elected for each plan. It may also include options for election by the insured.

Benefits at a Glance – Monthly Earnings (page 4): This definition will be case-specific to support the appropriate earnings definition for each plan.

Benefits at a Glance – Maximum Period of Payment (page 5): This provision will be case-specific to support the elected benefit payment duration for each plan. The plan may also provide multiple options for the insured to elect, in which event the headings will indicate “Option A” and “Option B” or other descriptive labels.

Definitions – Active Employment (page 6): This provision will be case-specific to support the requirements of each plan. The most common version is shown in the certificate.

## **LTD CERTIFICATE continued**

Definitions – Employee (page 7): This provision will be case-specific to support the requirements of each plan. The most common version is shown in the certificate. Reference to Employer locations in other countries, if used, will specify the countries. The term itself may also be changed to match the requirements of the plan, such as “member” or “associate.”

General Provisions – When Coverage Begins (2<sup>nd</sup> version on page 11): References to “Option 1 coverage” and “Option 2 coverage” if used may be changed to some other label describing the different benefit selections, such as “Core coverage” and “Buy-Up coverage” or “Basic coverage” and “Additional coverage.” The second reference may refer to multiple options, such as “Option 2, 3 or 4 coverage.”

Long Term Disability Benefit Information – Deductible Sources of Income (page 20): In the fourth regular bulleted item, the reference to 16-80 hours if used may be instead represented as days (2-10 days).

Long Term Disability Benefit Information – Non-Deductible Sources of Income (page 22): In the third bulleted item, the reference to 16-80 hours if used may be instead represented as days (2-10 days).

Long Term Disability Benefit Information – Pursuing Social Security Disability Insurance (SSDI) Benefits, and Receiving SSDI Benefits, and Duration of Payments, and When Payments End (all provisions on page 23): These four provisions will replace all of the provisions on pages 20-22 if the plan is sold as “Social Security Gap Filler” which only provides benefits when the claimant is not receiving benefits from Social Security. All of the provisions on pages 20-22 will be used with all other plans that integrate benefits with other sources of income.

Claim Information – Overpaid Claim (page 36): The last bracketed bullet: “Your failure to notify us promptly of your receipt of SSDI benefits” is for use with plans sold as “Social Security Gap Filler” which only provides benefits when the claimant is not receiving benefits from Social Security. It will not be used for other plans.

Claim Information – Consumer Notice (page 37): The insurer phone number and the Department’s address and phone numbers may be revised as needed in the future.

## **LTD POLICY AND CERTIFICATE AMENDMENTS**

All Policyholder, Group Policy Number and Employer data at the top, and the effective dates, will be case-specific.

Form LTD-PA1: References to names and locations of divisions, subsidiaries, affiliated companies and participating employers will be case-specific.

Form LTD-PA2: References to revised certificates, endorsements, amendments and riders will be case-specific.

Form LTD-PA4: References to the legal name of the Policyholder will be case-specific.

Form LTD-PA5: The provision names and the text of the provisions will only show text that was approved within the policy form. The amendment may include one or multiple provisions.

Form LTD-CA1: References to classes, if used, will be case-specific. References to certificate numbers, if used, will be case-specific. The data in the right footer, if used, will be case-specific.

Form LTD-CA2: References to classes, if used, will be case-specific. References to certificate numbers, if used, will be case-specific. The provision names and the text of the provisions will only show text that was approved within the policy/certificate form. The amendment may include one or multiple provisions. The data in the right footer, if used, will be case-specific.