

SERFF Tracking Number: SYMT-127637464 State: Arkansas
Filing Company: Symetra Life Insurance Company State Tracking Number: 49854
Company Tracking Number: LGC-10011
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Filing at a Glance

Company: Symetra Life Insurance Company

Product Name: Select Benefits

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only

Filing Type: Form

SERFF Tr Num: SYMT-127637464 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49854

Co Tr Num: LGC-10011

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Mary Ellen Mckendry, Jen
Franklin Disposition Date: 10/04/2011

Date Submitted: 09/22/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Accident Policy

Project Number: LGC-10011

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association, Trust

Filing Status Changed: 10/04/2011

State Status Changed: 10/04/2011

Created By: Jen Franklin

Corresponding Filing Tracking Number:

Filing Description:

Arkansas Department of Insurance

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jen Franklin

Symetra Life Insurance Company NAIC # 1129-68608

RE: Select Benefits Group Accident Policy

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011
Policy/Certificate Form LGC-10011P/LGC-10011C 10/11
Amendatory Rider LGC-10017AR 10/11
Employer Application LGC-9096AR 10/11

Enclosed please find copies of the above referenced form hereby submitted for approval and filing. Policy/Certificate form LGC-10011P/LGC-10011C 10/11 is a combined policy and certificate document. Variable information is indicated by brackets []. This is a new form and has not been filed before in Arkansas. This form replaces the Accident Policy/Certificate LGC-9072AR 11/05 which was approved by your office 6/27/2006. The policy is submitted in final printed form. Also enclosed is Amendatory Rider LGC-10017AR 10/11, the Employer Application LGC-9096AR 10/11.

The Select Benefits Accident Only policy/certificate includes the following limited benefits – hospital/medical benefits, surgical benefits, diagnostic x-ray and laboratory benefits; inpatient prescription drug benefits; and dental benefits.

The differences between Accident Policy/Certificate LGC-9072AR 11/05 and this new Accident Policy/Certificate Form LGC-10011P/LGC-10011C 10/11 are the benefit amount has been extended to \$10,000; the benefit structure has been modified to include one and three accident incidents each payable up to the calendar year maximum; COBRA provisions have been replaced with the Extension of Coverage Benefit; state specific issues, if any, are addressed in an Amendatory Rider.

The plan has no pre-existing condition limitations. This product will be marketed to employers who are permitted by state law to offer limited benefits and will be marketed by licensed agents and brokers.

We trust that with all this information you will be able to approve this filing. We hope to make this form effective upon your approval. Should you have any questions please contact me at 1-800-426-7784 ext. 68835, or my direct line at 425-256-8835. My email address is maryellen.mckendry@symetra.com.

Sincerely,

Mary Ellen McKendry
Senior Contract Analyst

Company and Contact

Filing Contact Information

Mary Ellen McKendry, Contract Analyst maryellen.mckendry@symetra.com
777 108th Avenue N.E., Suite 1200 425-256-8835 [Phone]
Bellevue, WA 98004

Filing Company Information

SERFF Tracking Number: SYMT-127637464 State: Arkansas
 Filing Company: Symetra Life Insurance Company State Tracking Number: 49854
 Company Tracking Number: LGC-10011
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011
 Symetra Life Insurance Company CoCode: 68608 State of Domicile: Washington
 777 108th Ave NE, Suite 1200 Group Code: 1129 Company Type: Insurance
 Bellevue, WA 98004-5135 Group Name: State ID Number:
 (800) 796-3872 ext. [Phone] FEIN Number: 91-0742147

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 filing x 50.00 = \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Symetra Life Insurance Company	\$50.00	09/22/2011	52014859
Symetra Life Insurance Company	\$100.00	09/27/2011	52186857

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/04/2011	10/04/2011

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	10/03/2011	10/03/2011	Mary Ellen Mckendry	10/04/2011	10/04/2011
Pending Industry Response	Rosalind Minor	09/27/2011	09/27/2011	Mary Ellen Mckendry	09/27/2011	09/27/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	group accident policy	Mary Ellen Mckendry	09/29/2011	09/29/2011

SERFF Tracking Number: SYMT-127637464 *State:* Arkansas
Filing Company: Symetra Life Insurance Company *State Tracking Number:* 49854
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TOI: H02G Group Health - Accident Only *Sub-TOI:* H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Disposition

Disposition Date: 10/04/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form (revised)	group accident policy	Approved-Closed	Yes
Form	group accident policy	Replaced	Yes
Form	employer application	Approved-Closed	Yes
Form (revised)	amendatory rider	Approved-Closed	Yes
Form	amendatory rider	Replaced	Yes

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/03/2011
Submitted Date 10/03/2011

Respond By Date

Dear Mary Ellen McKendry,

This will acknowledge receipt of the captioned filing.

Objection 1

- amendatory rider, LGC-10017AR (Form)

Comment:

With respect to adopted children, please refer to the 60-day period outlined under ACA 23-79-137(b) which states that...."the coverage required by this section shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and the application for coverage is filed within sixty (60) days after the birth of the minor....".

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: SYMT-127637464 State: Arkansas
 Filing Company: Symetra Life Insurance Company State Tracking Number: 49854
 Company Tracking Number: LGC-10011
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/04/2011
 Submitted Date 10/04/2011

Dear Rosalind Minor,

Comments:

Thank you for your letter.

Response 1

Comments: The correction has been made to the attached rider.

Related Objection 1

Applies To:

- amendatory rider, LGC-10017AR (Form)

Comment:

With respect to adopted children, please refer to the 60-day period outlined under ACA 23-79-137(b) which states that...."the coverage required by this section shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and the application for coverage is filed within sixty (60) days after the birth of the minor....".

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
amendatory rider	LGC-10017AR		Certificate Amendment, Insert Page, Endorsement or Rider	Initial			ARAccidentRider.pdf

Previous Version

<i>SERFF Tracking Number:</i>	<i>SYMT-127637464</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Symetra Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49854</i>
<i>Company Tracking Number:</i>	<i>LGC-10011</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Select Benefits</i>		
<i>Project Name/Number:</i>	<i>Accident Policy/LGC-10011</i>		
<i>amendatory rider</i>	<i>LGC- 10017AR</i>	<i>Certificate Amendment, Initial Insert Page, Endorsement or Rider</i>	<i>ARAccide ntRider.pd f</i>

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,

Jen Franklin, Mary Ellen Mckendry

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 09/27/2011

Submitted Date 09/27/2011

Respond By Date

Dear Mary Ellen McKendry,

This will acknowledge receipt of the captioned filing.

Objection 1

- group accident policy, LGC-10011P/LGC-10011C (Form)
- employer application, LGC-9096AR (Form)
- amendatory rider, LGC-10017AR (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 \$150.00. Please submit an additional \$100.00 for this submission.

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

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/27/2011
Submitted Date 09/27/2011

Dear Rosalind Minor,

Comments:

Thank you for your letter

Response 1

Comments: The additional \$100.00 filing has been submitted.

Related Objection 1

Applies To:

- group accident policy, LGC-10011P/LGC-10011C (Form)
- employer application, LGC-9096AR (Form)
- amendatory rider, LGC-10017AR (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 \$150.00. Please submit an additional \$100.00 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

SERFF Tracking Number: SYMT-127637464 *State:* Arkansas
Filing Company: Symetra Life Insurance Company *State Tracking Number:* 49854
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Product Name: Select Benefits
Project Name/Number: Accident Policy/LGC-10011

Sincerely,
Jen Franklin, Mary Ellen Mckendry

SERFF Tracking Number: SYMT-127637464 State: Arkansas
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 Company Tracking Number: LGC-10011
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Amendment Letter

Submitted Date: 09/29/2011

Comments:

I corrected an error I found in the policy. Attached is a revised copy.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LGC-10011P/LGC-10011C	Policy/Contr group	act/Fraternal accident Certificate: policy Amendment, Insert Page, Endorsement or Rider	Initial					FinalLGC10011PLGC-10011C.pdf

SERFF Tracking Number: SYMT-127637464 State: Arkansas
 Filing Company: Symetra Life Insurance Company State Tracking Number: 49854
 Company Tracking Number: LGC-10011
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Form Schedule

Lead Form Number: LGC-10011

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/04/2011	LGC- 10011P/LG C-10011C	Policy/Cont ract/Fratern al	group accident policy	Initial			FinalLGC100 11PLGC- 10011C.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved- Closed 10/04/2011	LGC- 9096AR	Application/ Enrollment Form	employer application	Initial			ARLGC-9096 10-11App .pdf
Approved- Closed 10/04/2011	LGC- 10017AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	amendatory rider	Initial			ARAccidentRi der.pdf

SELECT BENEFITS GROUP ACCIDENT POLICY

Policy Specifications

This **Policy** is issued to:

[ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

Premium Due Date: [February 1, 2011]

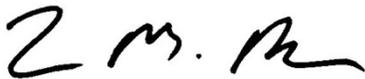
Policy Anniversary: [January 1, 2012]

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of [STATE].

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. This **Policy** renews on each **Policy Anniversary**.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the **Benefits** of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington.



Thomas Marra,
President



Michael Fry,
Executive Vice President

NOTICE TO BUYER

**THIS POLICY IS ISSUED AS AN ACCIDENT ONLY POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY ILLNESS.**

SYMETRA®

FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE
Bellevue, WA 98004

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General Provisions

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Introduction

This **Policy** is divided into two sections:

- 1. the **General Provisions**; and
- 2. the **Certificate of Coverage**.

Both sections together form the **Policy**.

The **Policyholder** will be responsible for giving the **Certificate of Coverage** to the covered **Certificateholder**.

Whenever **We** use the terms “**You or Your**” in this Introduction page or the **Policy** Provisions form, **We** mean the **Policyholder**.

Whenever **We** use the terms “**You, Your or Yourself**” in the **Certificate of Coverage**, **We** mean the **Certificateholder** [and/or **Certificateholder’s Dependents**].

You may add from time to time eligible new employees or members [or **Dependents**], as the case may be, in accordance with the terms of the **Policy**.

Schedule of Premium Rates

Policy Effective Date: [January 1, 2011]

All **Premium** payments are submitted to **Us** by the **Policyholder**.

Certificateholder [and Dependent] Accident Benefit	
<u>Accident Benefit</u>	<u>Premium Amount</u>
100% of Eligible Expenses up to \$[300 - 10,000] for each Accident occurrence up to a maximum of [1 or 3] occurrence(s) per person per Calendar Year .	

Policy Provisions

Assignment

The coverage provided under this **Policy** is not assignable, except as otherwise selected in this **Policy**.

Conformity with State Statutes

Any provision of this **Policy**, which is in conflict with the applicable statutes of the state in which this **Policy** is issued to the **Policyholder** is hereby amended to conform to the minimum requirements of such statutes.

Inadvertent Error

The **Insured** will not lose the amount of coverage due him because of inadvertent error by **You**:

- a. To provide the name of the **Insured** to **Us**; or
- b. To report a change in the amount of the **Insured's** coverage to **Us**.

Failure to report the termination of coverage of any **Insured** to **Us** will not continue the coverage beyond the date it would otherwise end.

You have no authority to pay **Premium** for individuals that are not **Certificateholders** or to continue coverage of terminated **Certificateholders**.

Legal Actions

No legal action may be brought to recover a disputed **Claim** amount under this **Policy**:

- a. Until 60 days have elapsed after **Proof of Loss** has been filed; or
- b. After 3 years from the end of the time within which **Proof of Loss** is required by this **Policy**.

Misstatement of Age

If the age of an **Insured** has been misstated, the **Benefit** payable will be the **Benefit** to which he is entitled due to actual age.

Policy Changes

This **Policy** may be changed at any time by written agreement between Symetra and officers of the **Policyholder**. Changes will be valid only if approved by an officer of Symetra and endorsed or attached to this **Policy**, and do not require the consent of any **Certificateholder [Dependent,] or Beneficiary**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

This **Policy** form, the Certificate of Coverage, the attached Application of the **Policyholder**, and all **Amendments, Endorsements or Riders** form the entire contract, and to the extent required by state law the applications, if any, of the **Insured** persons.

Entire Certificate

The Certificate of Coverage form, all **Amendments, Endorsements or Riders** form the entire Certificate.

Statements Not Warranties

In the absence of fraud, all statements made by **You** or by any **Certificateholder** will be deemed representations and not warranties. These statements will not be used to reduce or deny **Benefits** unless the statements are in a written application signed by **You** or the **Certificateholder**.

Pronouns

Masculine pronouns used in this **Policy** will apply to both genders.

Records of the Policyholder

You will give such data as may be required by **Us** to provide the coverage. This includes data on persons becoming covered, changes in the amount of coverage, and terminations of coverage. Payroll and other personnel records pertaining to **Your** coverage under this **Policy** will be open for review by **Us** at any reasonable time. Any additional records of **Yours** as may have a bearing on the coverage shall also be open for review by **Us** at any reasonable time.

Incontestability of Policy

We will not contest this **Policy** after it has been in force for two years with respect to **You**, except for nonpayment of **Premium**.

No statement made by an **Insured** relating to his insurability will be used to contest his coverage:

- a. After his coverage has been in force during his lifetime for two years; and
- b. Unless such statement is in writing and signed by him.

Workers' Compensation

This **Policy** is not in lieu of and does not affect any requirements for coverage by **Workers' Compensation Insurance**.

Premium Rates

Premium Rates will be the **Rates** shown in this **Policy** in accordance with coverage elected in the Application of the **Policyholder**. The initial **Rate** guarantee period will be shown in the Application of the **Policyholder**.

Payment of Premiums

The first **Premium** will be due on **Your Effective Date of Coverage** under this **Policy**. After that, **Premium** will be due monthly, unless **You** and Symetra agree on some other method of **Premium** payment.

Premiums are payable to **Us** at **Our** administrator's office.

Grace Period

After **You** pay the first **Premium** due, **You** have a grace period thereafter of 31 days in which to pay the **Premium** during which coverage will continue in force. If **You** do not pay the **Premium** by the 31st day, the **Policy** will automatically terminate. If **You** give **Us** advanced written notice of an earlier termination date, the **Policy** will terminate on the earlier date, provided however, that **Premium** is due for each day the **Policy** is in force.

Change in Premium Rates

We may change the **Premium Rate** for any coverage by giving **You** 31 days written notice. **We** may change the **Rates** on:

- a. The first **Policy Anniversary**; or
- b. Any **Premium** due date after the first **Policy Anniversary**; or
- c. Any **Amendment, Endorsement** or **Rider** effective date.

Premium Adjustment

Premium adjustment will be made when necessary. Refunds and credits are limited to the 3-month period prior to receipt of request for adjustment, so long as no claims have been paid for requested refund or credit period.

Termination by the Policyholder

You may terminate **Your** coverage provided under this **Policy** by mailing to **Us** 31 days prior written notice stating when such termination will be effective.

Termination by Symetra

We may terminate **Your** coverage under this **Policy** by giving at least 45 days prior written notice, when:

- a. **You** fail to comply with any of the minimum participation and contribution rules as communicated in writing; or
- b. Fraud upon **Us** has occurred; or
- c. **You** do not duly perform in good faith **Your** obligations under this **Policy**.

We may terminate **Your** coverage under this **Policy** by giving at least 10 days prior written notice, when **You** do not pay all **Premiums** that are due by the end of the grace period.

We may also terminate **Your** coverage under this **Policy** at any time for any reason after it has been in force for 12 months, provided **We** give 45 days prior written notice.

All written notices will be delivered to **You**, or mailed to **Your** last known address as shown on **Our** records and **We** will indicate in that notice the reason for the termination.

Reinstatement

If **Your** coverage ceases, **We** may reinstate such coverage, if requested in writing by **You**, and:

- a. All past due **Premiums**, including the grace period **Premium** are paid; and
- b. The current **Premium** is paid.

Renewal

We may renew **Your** coverage under this **Policy** on each **Policy Anniversary** by giving **You** 20 days prior written notice, indicating in that notice the amount of **Premium** due.

We may refuse to renew **Your** coverage under this **Policy** by giving **You** 45 days prior written notice indicating in that notice the reason for non-renewal of **Your** coverage under this **Policy**,

Governing Law: Jurisdiction

This **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 to ERISA.

SELECT BENEFITS GROUP ACCIDENT CERTIFICATE OF COVERAGE

Certificate Specifications

This **Policy** is issued to:

[ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

Policy Anniversary: [January 1, 2012]

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of [STATE].

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. This **Policy** renews on each **Policy Anniversary**.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the **Benefits** of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington



Thomas Marra,
President



Michael Fry,
Executive Vice President

NOTICE TO THE BUYER

This **Policy** is issued as an **Accident Only Policy**. It does not pay benefits for loss caused by illness.

**THIS POLICY PROVIDES LIMITED COVERAGE,
PLEASE READ YOUR POLICY CAREFULLY.**

SYMETRA[®]
FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE
Bellevue, WA 98004

Symetra[®] and the Symetra Financial logo are registered service marks of Symetra Life Insurance Company.

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Introduction

This is **Your** Certificate of Coverage. It describes the **Benefits** provided through the **Policyholder** under the **Policy** issued by Symetra Life Insurance Company to the **Policyholder**.

The complete terms of the coverage provided are set forth in this Certificate.

Keep this Certificate in a safe place. Instructions for submitting a **Claim** for **Benefits** appear at the end of this Certificate.

This **Certificate of Coverage** section replaces all others previously issued to **You** or your assignee.

Summary of Benefits and Benefit Amounts

This **Policy** is issued to: [ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

Policy Anniversary: [January 1, 2012]

Eligible Classes of Certificateholders

All eligible **Certificateholders** of the **Policyholder** who are defined as follows:

Class	Description
[Determined by the Policyholder.]

[Hourly Certificateholders

Benefit amounts are based on the following Levels and the amount of coverage selected by the **Policyholder** for each Level.

- Level 1: 1-90 Hours of Work per month
- Level 2: 91-130 Hours of Work per month
- Level 3: 131+ Hours of Work per month

The Level of coverage for which an **Insured** is eligible during the current month will be based on the number of hours worked in the prior month as reported by the **Policyholder**.]

Certificateholder [and Dependent] Accident Benefit

Accident Benefit Amount:

100% of **Eligible Expenses** up to \$[300 - 10,000] for each **Accident** occurrence up to a maximum of [1 or 3] occurrence(s) per person per **Calendar Year**.

Service Waiting Period

[Determined by the Policyholder.]

Definitions

Accident

an **Injury** sustained by **You**, which is a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

Amendment

a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Endorsement** or **Rider**.

Benefit

the dollar amount payable by **Us** to a claimant or assignee under this **Policy**.

Calendar Year

the period from January 1 through December 31 of the same year.

Certificateholder

- a. a person who is employed by, and paid by, the **Policyholder**; or
- b. a person who is employed by, and paid by an association acting in the capacity of the master **Policyholder** or the **Insured** of a member company of an association; or
- c. a person who is eligible for coverage under this **Policy** as a worker including one who is under exclusive contract with an employer [, or] individual/owner proprietor [or as a **Dependent**,] and is enrolled, and for whom **Premium** is paid.

Claim

a request for payment of **Benefits**.

Confined/Confinement

an **Inpatient** in a **Hospital** or other health care facility.

Contract Year

a period of one year commencing on the **Policyholder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the one-year period.

[Dependent

the following persons:

- a. **Your** spouse, as defined by state law [or your same or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law;]
- b. **Your** child who is under 26 years of age (limiting age); or
- c. **Your** child, who is incapable of self-support due to **Developmental Disability** or physical disability, provided the condition occurs prior to age 26.

Your child can include stepchildren, adopted children, or foster children, a judicially appointed minor ward of **Yours**, or a child legally placed for adoption and primarily dependent upon **You** for support.]

Developmental Disability

- a. a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation; or from
- b. a condition that requires treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains the "limiting age", which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

Effective Date

the date on which coverage under this Certificate begins.

Effective Date of Coverage

the date coverage under this Certificate goes into effect any eligible **Certificateholders** [and **Dependents**].

Eligible Expenses

services or supplies received by or on behalf of an **Insured** for treatment of a covered **Accident** that are not excluded under this **Policy**.

Emergency Room

a staffed and equipped **Hospital** room or **Hospital** area for the reception and evaluation of persons with conditions, such as **Illness** or **Injury**, requiring immediate medical attention. Treatment in an Emergency Room does not constitute admittance to the hospital.

Endorsement

a document that modifies this **Policy**, and becomes part of this Certificate, also known as an **Amendment** or **Rider**.

Experimental/Investigational

a method of care (e.g. any treatment, procedure, facility, equipment, drug device or supply) which meets one or more of the following criteria as determined by Symetra:

- a. the chosen method of care cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time such care is provided; or
- b. the method of care is currently undergoing review by the treating facility's Institutional Review Board or other body serving a similar function or if such review or approval is required by law or if the method of care is considered experimental or investigational by the Food and Drug Administration; or
- c. if Reliable Evidence shows that the method of care is the subject of ongoing phase I or phase II clinical trials or is the research, experimental, study or investigational arm of ongoing phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- d. if *Reliable Evidence* shows that the prevailing opinion among experts regarding the method of care is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis. In its determination of Experimental/Investigational, Symetra will rely on evidence produced by experts selected by Symetra. Conflicting evidence will defer to the exercise of independent judgment by Symetra.

"Reliable Evidence" shall mean only published reports and articles in the

Group Accident Certificate of Coverage [012345] authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device.

Hospital

- a licensed health care facility which:
- a. provides acute care; and
 - b. provides 24-hour nursing services; and
 - c. provides **Inpatient** therapeutic and diagnostic services for **Injury** or **Illness**; and
 - d. provides facilities for major surgery or has a formal arrangement with another health care facility for surgical facilities; and
 - e. is approved by the Joint Commission on the Accreditation of Health Care Facilities as a **Hospital**.

Hospital does **not** include:

- a. a rest home or nursing home, home for the aged, or convalescent home;
- b. a **Nursing Facility**;
- c. a **Hospice** or a place for **Custodial Care** or a **Birth Center**;
- d. a place primarily for the treatment of **Substance Abuse Disorders**; or
- e. a place primarily for the treatment of **Mental Disorders**.

Hours of Work Credit

the hours worked by **You** for whom contributions have been made on **Your** behalf by the **Policyholder**.

Illness

- a. physical sickness or disease; or
- b. a **Mental Disorder** as defined under this Certificate; or
- c. complications of pregnancy; or
- d. congenital abnormalities.

Injury

bodily harm that is caused by an **Accident** and results directly from the **Accident** and independently of all other cause.

Inpatient

a person who has been admitted to a **Hospital** or other health facility and for whom a room and

board charge has been made to receive diagnosis, treatment or other health services; and does not include a person who has received services in an Emergency Room, except when the **Hospital** admission is within 24 hours of an Emergency Room visit.

Insured

a person who is eligible for coverage under this Certificate as a **Certificateholder** [or as a **Dependent**], is enrolled, and for whom **Premium** is paid.

Lifetime Maximum

the dollar limitation on **Benefits** that will be paid for **You** during **Your** lifetime while covered under this Certificate.

Medically Necessary

any services or supplies provided for the diagnosis and treatment of a specific **Injury**, which are:

- a. ordered or recommended by a **Physician**;
- b. required for the treatment or management of a medical condition or symptom;
- c. the most appropriate supply or level of service which can safely be provided to **You**;
- d. provided in accordance with approved and generally accepted medical or surgical practice;
- e. not for the convenience of **You**, **Your Physician**, or another **Provider**;
- f. Not for services or supplies which are **Experimental or Investigational**;
- g. necessary for detoxification as an emergency medical condition provided **You** are not yet enrolled in other chemical treatment; and
- h. furnished in the least intensive type of medical care setting required by **Your** condition.

Services and supplies will **not** automatically be considered **Medically Necessary** because a **Physician** ordered them.

Nurse

any one of the following who is not a member of the **Insured's** immediate family or employed by the **Hospital** where the **Insured** is **Confined**:

- a. Licensed Practical Nurse (L.P.N.); or
- b. Licensed Vocational Nurse (L.V.N.); or
- c. graduated Registered Nurse (R.N).

Outpatient

Group Accident Certificate of Coverage [012345] an individual who receives health care services where he is not admitted to a **Hospital**.

Physician

a duly licensed member of a medical profession who:

- a. has an M.D. or D.O. degree;
- b. is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- c. provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- a. is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- b. provides medical services which are within the scope of his or her license or certificate;
- c. under applicable insurance law is considered a "physician" for purposes of this coverage;
- d. has the medical training and clinical expertise suitable to treat your condition;
- e. specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- f. a physician is not you or related to you.

Policy

the Group Accident Policy of which this Certificate forms a part that is issued to the **Policyholder**.

Policy Anniversary

the date twelve months after the date of the **Policyholder's Effective Date of Coverage** under the **Policy**, or as indicated on Summary of Benefits listed in this Certificate.

Policyholder

the entity named on the Application and the **Summary of Benefits**, who has applied for coverage under the **Policy**.

Premium

the dollar amount shown on the Schedule of **Premium Rates** page and amount paid by the **Policyholder** and/or **You** to keep the **Policy** in force.

Provider

any **Physician**, health professional, **Hospital**, **Nursing Facility**, home health agency or other person or recognized entity licensed to provide service for **Hospital** or medical services to **Insureds** covered under this **Policy**.

Rate

the pricing factor upon which the **Policyholder's** and/or **Your Premium** is based.

Reinstatement

the resumption of coverage that has lapsed under the **Policy**.

Renewal

continuance of coverage under the **Policy** beyond its original term by **Our** acceptance of the **Premium** for a new **Policy** term.

Rider

a document that modifies this **Policy**, and becomes part of this Certificate, also known as an **Amendment** or **Endorsement**.

Service Waiting Period

the length of time as specified in the **Summary of Benefits You** must wait from **Your** date of employment or application for coverage, until **Your** coverage is effective.

Summary of Benefits

the pages of this Certificate, which list the **Benefits** selected by the **Policyholder** and **You**.

Totally Disabled/ Total Disability

Your inability to perform the substantial and material duties of **Your** occupation.

We/Us/Our/Company

Symetra Life Insurance Company.

Workers' Compensation

benefit payments to any eligible individual as required by state law for accidents or occupational disease arising out of or in connection with the individual's employment.

Certificateholder Eligibility

Eligible Certificateholders - Hours of Work Credit

Each **Certificateholder** of a **Policyholder** who meets all of the following conditions is eligible for coverage under this **Policy**:

- a. performing all the normal duties of his job at the normal place of business of the **Policyholder**;
- b. working in an eligible class; and
- c. has worked and been paid for at least the minimum required hours at the normal place of business of the **Policyholder**.

The Date You are Eligible for Coverage

You become eligible for coverage upon completion of the **Service Waiting Period**.

Effective Date of Your Coverage

In order to become covered under this **Policy**, **You** must first enroll in writing on a form approved by **Us** giving the information **We** require.

If **You** are not required to contribute to the cost of **Your** coverage, coverage will become effective on the first day of the month following the latest of the following dates:

- a. the date **Premium** is received; or
- b. the date following completion of the **Service Waiting Period**, if any.

If **You** are required to contribute to the cost of **Your** coverage, the date coverage begins will depend on the date **You** enroll for coverage. However, it will be the first day of the month following the latest of the following dates:

- a. the date **Premium** is received; or
- b. the date following completion of the **Service Waiting Period**, if any; or
- c. the date **You** enroll for coverage.

Late Enrollment

If **You** fail to enroll **Yourself** [or **Your** eligible **Dependents**] within 31 days of **Your** [or **Your** eligible **Dependent's**] original eligibility date, then **You** [or **Your** eligible **Dependent**] will not be eligible to enroll for coverage under this **Policy** until the **Policyholder's** next open enrollment, if any. In the case of no open enrollment, late enrollment will be at the discretion of the **Policyholder**.

Dependent Eligibility

Please Note: This may not apply to **You** or **Your** coverage. **Dependent** coverage only applies if it is listed on **Your** Summary of Benefits and Benefit Amounts.

Eligible Dependents

A **Dependent of Yours** is eligible for coverage under this **Policy** if:

- a. **You** are an **Insured** under this **Policy**;
- b. **You** are in a class that qualifies for **Dependent Benefits**;
- c. the **Dependent** is not covered as a **Certificateholder** under this **Policy**; and
- d. if both **You** and **Your** spouse or domestic partner is covered under this **Policy** as **Certificateholders**, either, but not both, may elect to cover children who are eligible **Dependents**.

Date a Dependent is Eligible for Coverage

A **Dependent** is eligible to be an **Insured** on the later of:

- a. the date **You** become eligible for **Certificateholder** coverage; or
- b. the date **You** acquire **Your** first **Dependent** to include a newborn or newly placed adopted child; or
- c. the first day of the month following the date **You** acquire a spouse or domestic partner.

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** by submitting an enrollment form with the "Dependent box" checked within 31 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. the date **Premium** is received; or
- b. the date **You** become eligible for **Dependent** coverage; or
- c. the date the person becomes a **Dependent**.

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. the date **Premium** is received; or
- b. the date **You** become eligible for **Dependent** coverage; or
- c. the date **You** enroll for **Dependent** coverage.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 31 days following the birth or adoption of such child. Coverage will continue beyond the 31 day period for that child, if:

- a. **You** notify **Us** in writing of the birth or adoption of such child; and

- b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 31 days of the date of birth or adoption.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent** child is **Confined** to a **Hospital** or other health care facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or health care facility.

]

Benefit Changes

Change in Amounts of Benefits

Any change in the amount of **Benefits** due to a change in **Your** class or status, will be effective on the first business day of the month following the month in which **You** work and are paid for the minimum required hours, if any, provided:

- a. **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business; and
- b. **You** make any required payment for the change to be effective.

Changes in amounts of **Benefits**, due to an **Amendment**, **Endorsement** or **Rider** to this **Policy** or the **Policyholder's** coverage under this **Policy**, will take effect for **You** on the **Effective Date** of the **Amendment**, **Endorsement** or **Rider**.

Benefits payable under this **Policy** will be based on the coverage in effect at the time the eligible expenses were incurred.

Change in Amounts of Coverage

Once **You** have made **Your Benefit** elections for a given year, **You** cannot change those elections until the **Policyholder's** next open enrollment. Increases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change provided. **You** are performing all the normal duties of **Your** job at your normal place of business.

Decreases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change, provided **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business.

Termination Provisions

Termination of Your Coverage

Your coverage will cease on the earlier of:

- a. the date this **Policy** is canceled;
- b. the date the **Policyholder's** coverage ceases under this **Policy**; or
- c. the last day of the month in which the first of the following occurs:
 - i. **Your** membership in an eligible class ceases;
 - ii. **Your** employment with the **Policyholder** ceases;
 - iii. **You** or the **Policyholder** cease **Premium** payments for **Your** coverage;
 - iv. **You** are pensioned or retired, as defined by the **Policyholder**;
 - v. the date **You** begin active duty in the armed forces.

In addition, if **You** are classified as an "Hourly **Certificateholder**" **Your** coverage will cease on the first day of the month following any month in which **Your Hours of Work Credit** fall below the required number of hours, as established by the **Policyholder**.

[Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

- a. the date this **Policy** is canceled;
- b. the date **Your** coverage ceases;
- c. the date **We** cancel all **Dependent** coverage under this **Policy**; or
- d. last day of the month in which the first of the following occurs:
 - i. **You** are no longer in a class eligible for **Dependent** coverage; or
 - ii. the **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked, falls below the minimum required hours.

With respect to the **Benefits** of this **Policy**, coverage will be continued for a **Dependent** child beyond the "limiting age," as defined in the definition of **Dependent**, as long as the child continues to be both:

- a. incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical incapacity; and
- b. primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** not more than 31 days after the date such **Dependent** attains the "limiting age" , as defined in the definition of **Dependent**, and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the "limiting age."]

Reinstatement

If **You** have ceased to be eligible for coverage **You** may qualify for **Reinstatement** within 90 days from the date **You** were last eligible. **You** will be reinstated and eligible for coverage on the first day of the calendar month following the month in which **You** work and are paid for the minimum required hours. If **You** do not qualify for **Reinstatement** within 90 days from the date **You** were last eligible, **You** will be treated as a new worker.

Continuation of Coverage

Under the conditions that follow, **Benefits** for **You** [and **Your** covered **Dependents**] may continue beyond the day coverage would otherwise cease under the “Benefit Changes” and “Termination Provisions” sections if the required **Premium** is paid and this **Policy** is in force for the **Policyholder** during the continuation period shown below.

Coverage under this **Policy** will end on the first day **You** begin work for pay or profit with another employer.

Your Coverage

In the following circumstances, employment will be deemed to continue as shown, or until the **Policyholder**, acting under rules that preclude individual selection, terminates **Your** employment:

Continuation Period

Cause of Absence	Period in which Employment is deemed to continue	Coverage
Illness or Injury	6 months	All coverages
Temporary Lay-Off	2 months	All coverages
Leave of Absence	2 months	All coverages

Upon written request from the **Policyholder**, **We** may agree in writing to continue **Your** coverage for situations other than those listed above.

[Dependent Coverage

If any of the situations above apply to **You**, **Dependent** coverage may continue until **Your** coverage ends.]

Accident Benefit

Benefits will be paid as shown in the **Summary of Benefits** for **Eligible Expenses** that are incurred as a result of an **Accident** that occurs while the **You** are covered under this **Policy**.

The expenses must be incurred:

- a. Within 52 weeks from the date of the **Accident**; and
- b. The first expense must be incurred within 60 days after the date of the **Accident**.

The combined expenses paid for Medical, Dental, Surgical, Inpatient Hospital, X-ray and Lab and Inpatient Prescription Drug Benefits will not exceed the maximum Benefit amount shown in the **Summary of Benefits**.

Services and supplies paid under this Benefit include:

Medical Benefits

Medical **Benefits** will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy** for services and supplies rendered or prescribed by a licensed **Physician** or other licensed healthcare provider practicing within the scope of their license for the following:

- a. **Nursing** services;
- b. **Physician's** office visits;
- c. **Hospital Emergency Room** visits;
- d. **Outpatient Hospital** visits;
- e. Urgent care visits;
- f. Chiropractic visits;
- g. Rehabilitation services.

Medical Benefits will not be provided for services or supplies for preventive care, including but not limited to routine physicals, general health exams, routine immunizations and vaccinations.

Dental Benefits

Dental **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** or licensed Dentist in connection with an **Accident** while **You** are covered under this **Policy**. Procedures include:

- a. A closed or open reduction of a fracture;
- b. Dislocation of the jaw; or
- c. **Injury** to **Your** natural teeth.

Exclusions and Limitations

Dental **Benefits** will not be provided:

- a. For tooth re-implantology not resulting from an **Accident**;
- b. For procedures, services, or supplies, which do not meet accepted standards of dental practice;
- c. For treatment initiated while not covered under this **Policy**.

Surgical Benefits

Surgical **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** for surgical procedures performed in connection with an **Accident** while **You** are covered under this **Policy**.

Inpatient Hospital Benefits

Inpatient Hospital Benefits will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**.

Inpatient Hospital Benefits will be paid only if all of the following are met:

- a. the **Insured** is **Confined** in a **Hospital**; and
- b. a charge is made for room and board; and
- c. the entire duration of such **Hospital Confinement** is recommended and approved by a **Physician**; and
- d. **Confinement** is the result of a non-occupational **Accident**; and
- e. the services and supplies are not excluded under the Exclusions and Limitations provision of this **Policy**.

X-ray and Laboratory Benefits

Diagnostic X-ray and Laboratory **Benefits** will be provided for:

- a. **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**; and
- b. when they are ordered or performed by a **Physician**.

Inpatient Prescription Drugs

Inpatient Prescription Drugs Benefits will be provided for **Eligible Expenses** incurred if:

- a. **You** are **Confined** in a **Hospital**; and
- b. the drugs are prescribed by a **Physician**; and
- c. the drugs are administered in the **Hospital** by a licensed healthcare provider, in connection with an **Accident** while **You** are covered under this **Policy**.

Claim Provisions

Notice of Claim

Written notice of **Claim** must be given to **Us** within 20 days after the date any **Injury** or loss occurs or begins. If such notice is not furnished within that 20-day period, a **Claim** will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

Claim Forms

We will furnish forms for filing **Proof of Loss** after **We** receive the Notice of **Claim**. If such forms are not furnished within 15 days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of this **Policy** if he submits written **Proof of Loss** within the time set forth in the **Proof of Loss** provision.

Proof of Loss

Written proof of **Claim** must be given to **Us** within 90 days after the date of loss or treatment.

However, the **Claim** will not be denied or reduced if:

- a. It is not reasonably possible to give proof in that time; and
- b. Proof is submitted within 12 months from the date of loss or treatment.

This 12 month period will not apply when **You** are legally incapable of submitting proof. I

Proof of Loss means a **Claim** form or an itemized bill with ICD-9 Codes (or successor codes) from the healthcare provider sent to **Our Policy** administrator, before any **Benefits** may be paid under this **Policy**.

Time Payment of Claims

Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Payment of Benefits

Benefits payable under this **Policy** will be paid directly to:

- a. **You**;
- b. **Your** legally appointed guardian if **You** are not legally able to accept such **Benefits**; or
- c. a **Provider** upon **Your** assignment.

Any payment made in good faith by **Us** fully discharges **Us** to the extent of that payment. Failure to honor an assignment to a **Provider** due to inadvertent error will not subject **Us** to double payment.

Physical Examination and Autopsy

We, at **Our** own expense, will have the right to have **You** examined as often as **We** may reasonably require while a **Claim** is pending, and to require an autopsy in the case of death, unless it is forbidden by law.

Claim Procedures

Filing of Claims

We are responsible for evaluating all benefit **Claims** under this **Policy**. In order to receive **Benefits You** or **Your Authorized Representative** must complete, sign and submit a written **Claim** on a form approved by **Us**. An “**Authorized Representative**” means a person **You** authorize in writing to act on **Your** behalf. A person given the **Claim** authority to act by court order will be recognized and may submit **Claims** on **Your** behalf. The **Claim** form must be received within 90 days following the receipt of treatment to which the **Claim** relates unless

- (a) it was not reasonably possible to file the **Claim** within such time; and
- (b) the **Claim** is filed as soon as possible and in no event (except in the legal incapacity of the claimant) later than 12 months after the date of the receipt of the treatment to which the **Claim** relates.

We will make a decision on **Your Claim** within a reasonable time after it is received but no later than 30 days after the receipt of the **Claim**. If more information is required due to circumstances beyond the **Our** control, the time period may be extended up to an additional 15 days. **You** will be notified of the extension before the expiration of the initial 30-day period. **We** have the right to secure independent medical advice and to require such other evidence as **We** deem necessary in order to decide **Your Claim**. If **We** deny **Your Claim** in whole or in part, **You** will receive a written notification setting forth the reasons for the denial within a reasonable time period, but no later than 30 days after receipt of the **Claim** unless a determination that an extension of time for processing is needed as described above.

Right to Appeal a Denied Claim

If **You** disagree with a decision on a **Claim**, **You** or **Your** representative may, within 180 days of receiving an initial denial notice (or within the selected time period above if **You** receive no response regarding **Your Claim**) submit a written request to:

[**Select Benefit Administrators**
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699]

- a. Include comments and questions in writing.
- b. Review documents that apply to **Your Claim**.

If **Your** written request for review is not received within 180 days of receiving a denial notice, **You** will forfeit **Your** right to an appeal.

Important Appeal Deadline

Failure to comply within the 180 day deadline may cause **You** to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

Your written appeal should state the reasons that **You** feel **Your Claim** should not have been denied. It should include any additional facts and/or documents that **You** feel support **Your Claim**. **You** may also ask additional questions or make comments and **You** may review pertinent documents.

Notification of Adverse Benefit Decision

We will review and make a decision regarding **Your** claim within a reasonable period but no later than 30 days after it is submitted and **We** will notify **You** in writing of **Our** decision. If the decision remains the same, a denial, **We** will specify the reason for the denial and upon request, specify the **Policy** provisions, protocol or guideline relied upon which the decision is based.

If **Your** coverage is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health coverage, other than that which is provided by governmental entities or churches), **You** have a right to file a lawsuit under Section 502(a) of ERISA to recover benefits due **You** at any point after completion of an appeal. **You** may have other legal rights and remedies available under state or federal law.

Claims Fiduciary

We are designated as the **Claims** fiduciary for **Benefits** provided under the **Policy**. **We** have full discretion and authority to determine eligibility for **Benefits** and to construe and interpret all terms and provisions of the **Policy**.

Preemption of State Law

If applicable state law requires **Us** to take action on a **Claim** or appeal in a shorter timeframe, the shorter period will apply.

Extension of Coverage Benefit

Extension of Coverage applies to all **Benefits** shown in the **Summary of Benefits** of this **Policy**. **This Extension of Coverage Benefit** applies only to loss of accident coverage under this Select Benefits **Accident Insurance Policy**.

You [and **Your Dependents**] may qualify to temporarily extend the accident **Benefits** of this **Policy** at group rates (Extension of Coverage) in certain situations where coverage would otherwise end. **You** may only extend the **Benefits** of said **Policy** which **You** [and/or **Your Dependents**] had immediately prior to the date coverage ended.

You may choose Extension of Coverage for **Yourself** [and any covered **Dependent**] if **You** lose **Your** group accident coverage because of a reduction in hours or termination of employment (for reasons other than gross misconduct). [If **You** are a covered spouse or domestic partner, or **Dependent** child of a **Certificateholder**, **You** may choose Extension of Coverage for **Yourself** if **You** lose group accident coverage for any of the following reasons (qualifying event):

- a. **Your** spouse or domestic partner dies;

Group Accident Certificate of Coverage [012345]

- b. **You** spouse's or domestic partner's or, if a dependent, **You** parent's employment ends (for reasons other than gross misconduct), or his hours are reduced;
- c. **You** or, or if a **Dependent**, **Your** parents' divorce or legally separate;
- d. **Your** spouse or domestic partner, or parent becomes entitled to Medicare; or

Covered **Dependent** children of a **Certificateholder** may continue coverage if they cease to qualify as **Dependents** under the group policy. **You** or **Your Dependent** are responsible for notifying the **Policyholder** when certain qualifying events occur. These events include divorce or legal separation and ceasing to qualify as a **Dependent** under the group plan.]

The **Policyholder** must be notified within 60 days of the later of:

- a. the event; or
- b. the date coverage would end because of the event.

You have 60 days to elect Extension of Coverage from the later of:

- a. the date **You** lose coverage due to the event; or
- b. the date the **Policyholder** informed **You** that **You** may choose Extension of Coverage.

If **You** do not choose Extension of Coverage, **Your** coverage under this policy with the **Policyholder** will end. If **You** choose Extension of Coverage, it will be identical to coverage **You** [and/or **Your Dependents**] had immediately prior to the date coverage ended.

If **You** elect Extension of Coverage, **You** must pay the full cost of coverage each month. **You** have the option to continue coverage for **Yourself** [and/or **Your** covered **Dependents**] for 18 months if **You** lose group accident coverage due to termination of employment or a reduction in hours. A longer coverage period may be available in case of disability. If the Social Security Administration determines that **You** [or a covered **Dependent** is] [are] disabled by the end of the first 60 days of Extension of Coverage following termination of employment, coverage for the disabled person [and all covered **Dependents**] may be extended for an additional 11 months up to a total of 29 months. [This same 11-month extension is provided to a disabled child if the child is born or placed for adoption during the Extension of Coverage period and the child is determined to be disabled within the first 60 days of Extension of Coverage]. In order to qualify for coverage extension, **You** must notify the **Policyholder** before the end of the 18-month Extension of Coverage period and provide a copy of the Social Security disability determination letter within 60 days of the determination date. [If, during the 18-month Extension of Coverage period, another qualifying event takes place, coverage may be extended for up to 36 months for covered **Dependents**. In no case will the total Extension of Coverage period exceed 36 months].

Extension of Coverage may be terminated for any of the following reasons:

- a. the **Policyholder** no longer provides group accident coverage to any **Certificateholders**;
- b. **You** do not pay the **Premium** for **Your** Extension of Coverage on time;
- c. **You** become covered under another group accident plan that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your Extension of Coverage election;
- d. **You** become entitled to Medicare after the date of **Your** Extension of Coverage election; or
- e. the person whose Social Security disability enabled the extended coverage is determined to have recovered.

If **You** have any questions about Extension of Coverage, contact the **Policyholder**.

Non-Duplication of Benefits

To avoid duplication of benefit payments to an **Insured**, **Benefits** under this **Policy** will be coordinated with benefits payable under the Select Benefits Group Indemnity Policy and Select Benefits Group Outpatient Prescription Drug Policy, if applicable.

Exclusions and Limitations

Whether or not these may be considered accidents, benefits will not be paid for any expense for services or supplies:

- a. for which there is no charges made which an insurer is required to pay;
- b. received after Termination of Coverage, except as provided under this **Policy**;
- c. received as a result of participation in any sport for pay or profit;
- d. received as a result of participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding;
- e. received as a result of participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
- f. received as a result of participation or driving in any organized scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
- g. for hernia repair, including complications;
- h. related to cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- i. related to dental care, except as required on account of **Injury** resulting from an **Accident** while covered under this **Policy**;
- j. which are not **Medically Necessary**;
- k. for durable medical equipment;
- l. that are not approved or accepted as essential to the treatment of the **Injury** by any of the following:
 - i. the American Medical Association;
 - ii. the U.S. Surgeon General;
 - iii. Department of Public Health; or
 - iv. the National Institute of Health.
- m. for disease, **Illness**, or bacterial infection, except infection resulting directly from an **Accidental Injury**;
- n. for an **Injury** or **Illness** caused wholly or partly, directly or indirectly by:
 - i. declared or undeclared war or act of war;
 - ii. intentionally committing or attempting to commit an assault or felony;
 - iii. intentionally self-inflicted **Injury**, while sane or insane.
- o. any **Illness** or **Injury** covered by any **Worker's Compensation** Act or similar law.

SYMETRA[®]

FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004

APPLICATION

Select Benefits

[Mail to:
Select Benefit Administrators
P.O. Box 440
(overnight deliveries to: 118 3rd Street East)
Ashland, WI 54806
P 1-800-497-3699
F (715) 682-5919]

Directions:

1. Complete this form in its entirety.
2. Attach the plan matrix chosen by the Policyholder to the back of this sheet.

NOTE: All incomplete applications will not be accepted, and will be returned to the Agent/Broker.

Policyholder (Legal Name) _____ Administrative Contact _____
Street Address _____ Title _____
City _____ State _____ Zip _____ Phone (____) _____ Fax (____) _____
Mailing Address _____ Email _____
City _____ State _____ Zip _____ Requested Effective Date _____

SIC Code _____ Number of Full-Time Certificateholders _____ Number of Eligible Certificateholders _____

Waiting Period for Plan Eligibility

- First of the month following: Date of hire 30 days of employment 60 days of employment 90 days of employment
 Other _____

Eligible Classes of Certificateholders: Full-time Part-time Hourly Temporary Other _____

Policyholder Contribution (please specify % or dollar amount) _____ Hourly or _____ Monthly

Policy Selection: Indemnity (Medical) Outpatient Prescription Drug Accident Critical Illness Other _____

Plan(s) Selected _____ As named on this quote/ proposal matrix: _____

Deposit: A deposit of \$ _____ is hereby submitted to apply to the first premium payment due under the policy, if issued. Coverage is subject to Symetra Home Office approval and nothing contained herein shall be binding until approved. The deposit will be returned in full if coverage is not issued. Payment of a premium after delivery of the policy shall constitute acceptance of the terms and conditions.

- Conditions:**
1. This Application is subject to acceptance by Symetra Life Insurance Company.
 2. The initial rate guarantee will be for 12 months following the effective date.
 3. This policy is not intended to replace major medical coverage.
 4. All necessary administrative information concerning all Certificateholders shall be subject to the provisions of the policy and shall be furnished to Symetra by the Policyholder.
 5. All benefits shall be in accordance with those agreed to by Symetra.

Please read the following notice that we are required by law to give to you.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison..

Policyholder's Application and Certification:

- By checking this box, I am indicating that I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued.

No person to be covered for Critical Illness may be covered by any Title XIX program, designated as Medicaid or any similar name.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

By checking this box, I am indicating that:

- a) all information set forth above is correct to the best of my knowledge;
- b) I have complied fully with the underwriting guidelines;
- c) I have explained this Application and the proposed insurance plan in detail to the applicant; and
- d) to the best of my knowledge, the above Policyholder is financially sound.

By checking this box, I am further indicating that all agents involved in the presentation of this account:

- a) are licensed by Symetra Life Insurance Company; or
- b) have submitted the necessary paperwork to become a licensed agent through Symetra Life Insurance Company.

Agency _____

Agent Name (Print) _____ Date _____

Address _____ Agent License Number _____

City _____ State _____ Zip _____ Tax ID Number _____

Phone (_____) _____ Fax (_____) _____ Writing Number _____

Email _____

ARKANSAS AMENDATORY RIDER

Policy/Certificate LGC-10011P/LGC-10011C 10/11:

The Policy and Certificate to which this rider is attached is amended as follows:

INTRODUCTION, Policy, page 3 and Certificate of Coverage page 3, the following provision is added:

INTRODUCTION

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
1-800-426-7784

If we at Symetra Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804
1-800-852-5494

DEFINITIONS section, definition of Illness is deleted in its entirety and replaced with the following:

“Illness

- a. Physical sickness or disease; or
- b. A mental disorder; or
- c. Complications of pregnancy; or
- d. Premature birth; or
- e. Congenital abnormalities.”

DEPENDENT ELIGIBILITY section, Effective Date of Coverage section is deleted in its entirety and replaced with the following:

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** by submitting an enrollment form with the Dependent box checked within 31 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. The date **Premium** is received; or
- b. The date **You** become eligible for **Dependent** coverage; or
- c. The date the person becomes a **Dependent**.

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. The date **Premium** is received; or
- b. The date **You** become eligible for **Dependent** coverage; or
- c. The date **You** enroll for **Dependent** coverage.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 60 days following the birth or adoption of such child. Coverage will continue beyond the 60 day period for that child, if:

- a. **You** notify **Us** in writing of the birth or adoption of such child; and
- b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 90 days of the date of birth or adoption.

With respect to an adopted child, the **Policy** will provide coverage for any minor under the charge, care, and control of the **Insured** whom the **Insured** has filed a petition to adopt. Coverage shall begin on the date of the filing of a petition for adoption if the **Insured** applies for coverage within sixty (60) days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent** child is **Confined** to a **Hospital** or other health care facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or health care facility.”

TERMINATION PROVISIONS section, Termination of Dependent Coverage section is deleted in its entirety and replaced with the following:

“Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

- a. The date this **Policy** is canceled;
- b. The date **Your** coverage ceases;
- c. The date **We** cancel all **Dependent** coverage under this **Policy**; or
- d. Last day of the month in which the first of the following occurs:
 - i. **You** are no longer in a class eligible for **Dependent** coverage; or
 - ii. The **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked falls below the minimum required hours.

With respect to the **Benefits** and child **Premium Rates** of this **Policy**, coverage and the child **Premium Rates** will be continued for a **Dependent** child beyond the limiting age as long as the child continues to be both:

- a. Incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical handicap; and
- b. Primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** after the date such **Dependent** attains the limiting age and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the limiting age.

See "Continuation of Coverage" provisions for exceptions to Termination Provisions.

All other terms and conditions of the Policy remain unchanged.

Symetra Life Insurance Company

A handwritten signature in black ink that reads "George Pagos". The signature is written in a cursive, slightly slanted style.

George Pagos,

Secretary

Symetra® and the Symetra Financial logo are registered service marks of Symetra Life Insurance Company.

<i>SERFF Tracking Number:</i>	<i>SYMT-127637464</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Symetra Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49854</i>
<i>Company Tracking Number:</i>	<i>LGC-10011</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Select Benefits</i>		
<i>Project Name/Number:</i>	<i>Accident Policy/LGC-10011</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/04/2011
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/04/2011
Comments: This form replaces LGC-9096AR 6/08 approved 6/27/2006		
Attachment: ARLGC-9096 10-11App .pdf		

READABILITY CERTIFICATION

I hereby certify on behalf of Symetra Life Insurance Company that the attached form meets the reading ease score established in the Arkansas Policy Language Simplification Act 23-86-203. The combined Flesh score is 50.4 .



Michael Fry
Executive Vice President
Symetra Life Insurance Company

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FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004

APPLICATION Select Benefits

[Mail to:
Select Benefit Administrators of America
P.O. Box 440
(overnight deliveries to: 118 3rd Street East)
Ashland, WI 54806
P 1-800-497-3699
F (715) 682-5919]

Directions:

1. Complete this form in its entirety.
2. Attach the plan matrix chosen by the Policyholder to the back of this sheet.

NOTE: All incomplete applications will not be accepted, and will be returned to the Agent/Broker.

Policyholder (Legal Name) _____ Administrative Contact _____
Street Address _____ Title _____
City _____ State _____ Zip _____ Phone (____) _____ Fax (____) _____
Mailing Address _____ Email _____
City _____ State _____ Zip _____ Requested Effective Date _____

SIC Code _____ Number of Full-Time Certificateholders _____ Number of Eligible Certificateholders _____

Waiting Period for Plan Eligibility

- First of the month following: Date of hire 30 days of employment 60 days of employment 90 days of employment
 Other _____

Eligible Classes of Certificateholders: Full-time Part-time Hourly Temporary Other _____

Policyholder Contribution (please specify % or dollar amount) _____ Hourly or _____ Monthly

Policy Selection: Indemnity (Medical) Outpatient Prescription Drug Accident Critical Illness Other _____

Plan(s) Selected _____ As named on this quote/ proposal matrix: _____

Deposit: A deposit of \$ _____ is hereby submitted to apply to the first premium payment due under the policy, if issued. Coverage is subject to Symetra Home Office approval and nothing contained herein shall be binding until approved. The deposit will be returned in full if coverage is not issued. Payment of a premium after delivery of the policy shall constitute acceptance of the terms and conditions.

- Conditions:**
1. This Application is subject to acceptance by Symetra Life Insurance Company.
 2. The initial rate guarantee will be for 12 months following the effective date.
 3. This policy is not intended to replace major medical coverage.
 4. All necessary administrative information concerning all Certificateholders shall be subject to the provisions of the policy and shall be furnished to Symetra by the Policyholder.
 5. All benefits shall be in accordance with those agreed to by Symetra.

Please read the following notice that we are required by law to give to you.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison..

Policyholder's Application and Certification:

- By checking this box, I am indicating that I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued.

No person to be covered for Critical Illness may be covered by any Title XIX program, designated as Medicaid or any similar name.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

By checking this box, I am indicating that:

- a) all information set forth above is correct to the best of my knowledge;
- b) I have complied fully with the underwriting guidelines;
- c) I have explained this Application and the proposed insurance plan in detail to the applicant; and
- d) to the best of my knowledge, the above Policyholder is financially sound.

By checking this box, I am further indicating that all agents involved in the presentation of this account:

- a) are licensed by Symetra Life Insurance Company; or
- b) have submitted the necessary paperwork to become a licensed agent through Symetra Life Insurance Company.

Agency _____

Agent Name (Print) _____ Date _____

Address _____ Agent License Number _____

City _____ State _____ Zip _____ Tax ID Number _____

Phone (_____) _____ Fax (_____) _____ Writing Number _____

Email _____

SERFF Tracking Number: SYMT-127637464 State: Arkansas
 Filing Company: Symetra Life Insurance Company State Tracking Number: 49854
 Company Tracking Number: LGC-10011
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Select Benefits
 Project Name/Number: Accident Policy/LGC-10011

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/22/2011	Form	group accident policy	09/29/2011	FinalLGC10011P.pdf (Superseded)
09/22/2011	Form	amendatory rider	10/04/2011	ARAccidentRider.pdf (Superseded)

SELECT BENEFITS GROUP ACCIDENT POLICY

Policy Specifications

This **Policy** is issued to:

[ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

Premium Due Date: [February 1, 2011]

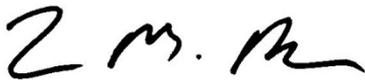
Policy Anniversary: [January 1, 2012]

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of [STATE].

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. This **Policy** renews on each **Policy Anniversary**.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the **Benefits** of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington.



Thomas Marra,
President



George Pagos,
Secretary

NOTICE TO BUYER

**THIS POLICY IS ISSUED AS AN ACCIDENT ONLY POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY ILLNESS.**

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Symetra Life Insurance Company
777 108th Avenue NE
Bellevue, WA 98004

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General Provisions

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Introduction

This **Policy** is divided into two sections:

1. the **General Provisions**; and
2. the **Certificate of Coverage**.

Both sections together form the **Policy**.

The **Policyholder** will be responsible for giving the **Certificate of Coverage** to the covered **Certificateholder**.

Whenever **We** use the terms "**You or Your**" in this Introduction page or the **Policy** Provisions form, **We** mean the **Policyholder**.

Whenever **We** use the terms "**You, Your or Yourself**" in the **Certificate of Coverage**, **We** mean the **Certificateholder** [and/or **Certificateholder's Dependents**].

You may add from time to time eligible new employees or members [or **Dependents**], as the case may be, in accordance with the terms of the **Policy**.

Schedule of Premium Rates

Policy Effective Date: [January 1, 2011]

All **Premium** payments are submitted to **Us** by the **Policyholder**.

Certificateholder [and Dependent] Accident Benefit

Accident Benefit

100% of **Eligible Expenses** up to \$[300 - 10,000] for each **Accident** occurrence up to a maximum of [1 or 3] occurrence(s) per person per **Calendar Year**.

Premium Amount

Policy Provisions

Assignment

The coverage provided under this **Policy** is not assignable, except as otherwise selected in this **Policy**.

Conformity with State Statutes

Any provision of this **Policy**, which is in conflict with the applicable statutes of the state in which this **Policy** is issued to the **Policyholder** is hereby amended to conform to the minimum requirements of such statutes.

Inadvertent Error

The **Insured** will not lose the amount of coverage due him because of inadvertent error by **You**:

- a. To provide the name of the **Insured** to **Us**; or
- b. To report a change in the amount of the **Insured's** coverage to **Us**.

Failure to report the termination of coverage of any **Insured** to **Us** will not continue the coverage beyond the date it would otherwise end.

You have no authority to pay **Premium** for individuals that are not **Certificateholders** or to continue coverage of terminated **Certificateholders**.

Legal Actions

No legal action may be brought to recover a disputed **Claim** amount under this **Policy**:

- a. Until 60 days have elapsed after **Proof of Loss** has been filed; or
- b. After 3 years from the end of the time within which **Proof of Loss** is required by this **Policy**.

Misstatement of Age

If the age of an **Insured** has been misstated, the **Benefit** payable will be the **Benefit** to which he is entitled due to actual age.

Policy Changes

This **Policy** may be changed at any time by written agreement between Symetra and officers of the **Policyholder**. Changes will be valid only if approved by an officer of Symetra and endorsed or attached to this **Policy**, and do not require the consent of any **Certificateholder [Dependent,] or Beneficiary**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

This **Policy** form, the Certificate of Coverage, the attached Application of the **Policyholder**, and all **Amendments, Endorsements** or **Riders** form the entire contract, and to the extent required by state law the applications, if any, of the **Insured** persons.

Entire Certificate

The Certificate of Coverage form, all **Amendments, Endorsements** or **Riders** form the entire Certificate.

Statements Not Warranties

In the absence of fraud, all statements made by **You** or by any **Certificateholder** will be deemed representations and not warranties. These statements will not be used to reduce or deny **Benefits** unless the statements are in a written application signed by **You** or the **Certificateholder**.

Pronouns

Masculine pronouns used in this **Policy** will apply to both genders.

Records of the Policyholder

You will give such data as may be required by **Us** to provide the coverage. This includes data on persons becoming covered, changes in the amount of coverage, and terminations of coverage. Payroll and other personnel records pertaining to **Your** coverage under this **Policy** will be open for review by **Us** at any reasonable time. Any additional records of **Yours** as may have a bearing on the coverage shall also be open for review by **Us** at any reasonable time.

Incontestability of Policy

We will not contest this **Policy** after it has been in force for two years with respect to **You**, except for nonpayment of **Premium**.

No statement made by an **Insured** relating to his insurability will be used to contest his coverage:

- a. After his coverage has been in force during his lifetime for two years; and
- b. Unless such statement is in writing and signed by him.

Workers' Compensation

This **Policy** is not in lieu of and does not affect any requirements for coverage by **Workers' Compensation Insurance**.

Premium Rates

Premium Rates will be the **Rates** shown in this **Policy** in accordance with coverage elected in the Application of the **Policyholder**. The initial **Rate** guarantee period will be shown in the Application of the **Policyholder**.

Payment of Premiums

The first **Premium** will be due on **Your Effective Date of Coverage** under this **Policy**. After that, **Premium** will be due monthly, unless **You** and Symetra agree on some other method of **Premium** payment.

Premiums are payable to **Us** at **Our** administrator's office.

Grace Period

After **You** pay the first **Premium** due, **You** have a grace period thereafter of 31 days in which to pay the **Premium** during which coverage will continue in force. If **You** do not pay the **Premium** by the 31st day, the **Policy** will automatically terminate. If **You** give **Us** advanced written notice of an earlier termination date, the **Policy** will terminate on the earlier date, provided however, that **Premium** is due for each day the **Policy** is in force.

Change in Premium Rates

We may change the **Premium Rate** for any coverage by giving **You** 31 days written notice. **We** may change the **Rates** on:

- a. The first **Policy Anniversary**; or
- b. Any **Premium** due date after the first **Policy Anniversary**; or
- c. Any **Amendment, Endorsement** or **Rider** effective date.

Premium Adjustment

Premium adjustment will be made when necessary. Refunds and credits are limited to the 3-month period prior to receipt of request for adjustment, so long as no claims have been paid for requested refund or credit period.

Termination by the Policyholder

You may terminate **Your** coverage provided under this **Policy** by mailing to **Us** 31 days prior written notice stating when such termination will be effective.

Termination by Symetra

We may terminate **Your** coverage under this **Policy** by giving at least 45 days prior written notice, when:

- a. **You** fail to comply with any of the minimum participation and contribution rules as communicated in writing; or
- b. Fraud upon **Us** has occurred; or
- c. **You** do not duly perform in good faith **Your** obligations under this **Policy**.

We may terminate **Your** coverage under this **Policy** by giving at least 10 days prior written notice, when **You** do not pay all **Premiums** that are due by the end of the grace period.

We may also terminate **Your** coverage under this **Policy** at any time for any reason after it has been in force for 12 months, provided **We** give 45 days prior written notice.

All written notices will be delivered to **You**, or mailed to **Your** last known address as shown on **Our** records and **We** will indicate in that notice the reason for the termination.

Reinstatement

If **Your** coverage ceases, **We** may reinstate such coverage, if requested in writing by **You**, and:

- a. All past due **Premiums**, including the grace period **Premium** are paid; and
- b. The current **Premium** is paid.

Renewal

We may renew **Your** coverage under this **Policy** on each **Policy Anniversary** by giving **You** 20 days prior written notice, indicating in that notice the amount of **Premium** due.

We may refuse to renew **Your** coverage under this **Policy** by giving **You** 45 days prior written notice indicating in that notice the reason for non-renewal of **Your** coverage under this **Policy**,

Governing Law: Jurisdiction

This **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 to ERISA.

SELECT BENEFITS GROUP ACCIDENT CERTIFICATE OF COVERAGE

Certificate Specifications

This **Policy** is issued to:

[ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

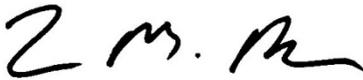
Policy Anniversary: [January 1, 2012]

Governing Jurisdiction: This **Policy** is delivered in and governed by the laws of [STATE].

This **Policy** has been issued in consideration of the signed Application and payment of **Premium**. This **Policy** renews on each **Policy Anniversary**.

Symetra Life Insurance Company issues this **Policy** and agrees to pay the **Benefits** of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this **Policy Effective Date** and caused it to be duly countersigned at Bellevue, Washington



Thomas Marra,
President



George Pagos,
Secretary

NOTICE TO THE BUYER

This **Policy** is issued as an Accident Only Policy. It does not pay benefits for loss caused by illness.

**THIS POLICY PROVIDES LIMITED COVERAGE,
PLEASE READ YOUR POLICY CAREFULLY.**

SYMETRA[®]

FINANCIAL

Symetra Life Insurance Company
777 108th Avenue NE
Bellevue, WA 98004

Symetra[®] and the Symetra Financial logo are registered service marks of Symetra Life Insurance Company.

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Introduction

This is **Your** Certificate of Coverage. It describes the **Benefits** provided through the **Policyholder** under the **Policy** issued by Symetra Life Insurance Company to the **Policyholder**.

The complete terms of the coverage provided are set forth in this Certificate.

Keep this Certificate in a safe place. Instructions for submitting a **Claim** for **Benefits** appear at the end of this Certificate.

This **Certificate of Coverage** section replaces all others previously issued to **You** or your assignee.

Summary of Benefits and Benefit Amounts

This **Policy** is issued to: [ABC Company]

Policy Number: [012345]

Policy Effective Date: [January 1, 2011]

Policy Anniversary: [January 1, 2012]

Eligible Classes of Certificateholders

All eligible **Certificateholders** of the **Policyholder** who are defined as follows:

Class	Description
[Determined by the Policyholder.]

[Hourly Certificateholders

Benefit amounts are based on the following Levels and the amount of coverage selected by the **Policyholder** for each Level.

- Level 1: 1-90 Hours of Work per month
- Level 2: 91-130 Hours of Work per month
- Level 3: 131+ Hours of Work per month

The Level of coverage for which an **Insured** is eligible during the current month will be based on the number of hours worked in the prior month as reported by the **Policyholder**.]

Certificateholder [and Dependent] Accident Benefit

Accident Benefit Amount:

100% of **Eligible Expenses** up to \$[300 - 10,000] for each **Accident** occurrence up to a maximum of [1 or 3] occurrence(s) per person per **Calendar Year**.

Service Waiting Period

[Determined by the Policyholder.]

Definitions

Accident

an **Injury** sustained by **You**, which is a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

Amendment

a document that modifies this **Policy**, and becomes part of this **Policy**, also known as an **Endorsement** or **Rider**.

Benefit

the dollar amount payable by **Us** to a claimant or assignee under this **Policy**.

Calendar Year

the period from January 1 through December 31 of the same year.

Certificateholder

- a person who is employed by, and paid by, the **Policyholder**; or
- a person who is employed by, and paid by an association acting in the capacity of the master **Policyholder** or the **Insured** of a member company of an association; or
- a person who is eligible for coverage under this **Policy** as a worker including one who is under exclusive contract with an employer [, or] individual/owner proprietor [or as a **Dependent**,] and is enrolled, and for whom **Premium** is paid.

Claim

a request for payment of **Benefits**.

Confined/Confinement

an **Inpatient** in a **Hospital** or other health care facility.

Contract Year

a period of one year commencing on the **Policyholder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the one-year period.

[Dependent

the following persons:

- Your** spouse, as defined by state law [or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law;]
- Your** child who is under 26 years of age (limiting age); or
- Your** child, who is incapable of self-support due to **Developmental Disability** or physical disability, provided the condition occurs prior to age 26.

Your child can include stepchildren, adopted children, or foster children, a judicially appointed minor ward of **Yours**, or a child legally placed for adoption and primarily dependent upon **You** for support.]

Developmental Disability

- a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation; or from
- a condition that requires treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains the "limiting age", which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

Effective Date

the date on which coverage under this Certificate begins.

Effective Date of Coverage

the date coverage under this Certificate goes into effect any eligible **Certificateholders** [and **Dependents**].

Eligible Expenses

services or supplies received by or on behalf of an **Insured** for treatment of a covered **Accident** that are not excluded under this **Policy**.

Emergency Room

a staffed and equipped **Hospital** room or **Hospital** area for the reception and evaluation of persons with conditions, such as **Illness** or **Injury**, requiring immediate medical attention. Treatment in an Emergency Room does not constitute admittance to the hospital.

Endorsement

a document that modifies this **Policy**, and becomes part of this Certificate, also known as an **Amendment** or **Rider**.

Experimental/Investigational

a method of care (e.g. any treatment, procedure, facility, equipment, drug device or supply) which meets one or more of the following criteria as determined by Symetra:

- a. the chosen method of care cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time such care is provided; or
- b. the method of care is currently undergoing review by the treating facility's Institutional Review Board or other body serving a similar function or if such review or approval is required by law or if the method of care is considered experimental or investigational by the Food and Drug Administration; or
- c. if Reliable Evidence shows that the method of care is the subject of ongoing phase I or phase II clinical trials or is the research, experimental, study or investigational arm of ongoing phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- d. if *Reliable Evidence* shows that the prevailing opinion among experts regarding the method of care is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis. In its determination of Experimental/Investigational, Symetra will rely on evidence produced by experts selected by Symetra. Conflicting evidence will defer to the exercise of independent judgment by Symetra.

"Reliable Evidence" shall mean only published reports and articles in the

Group Accident Certificate of Coverage [012345] authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device.

Hospital

- a licensed health care facility which:
- a. provides acute care; and
 - b. provides 24-hour nursing services; and
 - c. provides **Inpatient** therapeutic and diagnostic services for **Injury** or **Illness**; and
 - d. provides facilities for major surgery or has a formal arrangement with another health care facility for surgical facilities; and
 - e. is approved by the Joint Commission on the Accreditation of Health Care Facilities as a **Hospital**.

Hospital does **not** include:

- a. a rest home or nursing home, home for the aged, or convalescent home;
- b. a **Nursing Facility**;
- c. a **Hospice** or a place for **Custodial Care** or a **Birth Center**;
- d. a place primarily for the treatment of **Substance Abuse Disorders**; or
- e. a place primarily for the treatment of **Mental Disorders**.

Hours of Work Credit

the hours worked by **You** for whom contributions have been made on **Your** behalf by the **Policyholder**.

Illness

- a. physical sickness or disease; or
- b. a **Mental Disorder** as defined under this Certificate; or
- c. complications of pregnancy; or
- d. congenital abnormalities.

Injury

bodily harm that is caused by an **Accident** and results directly from the **Accident** and independently of all other cause.

Inpatient

a person who has been admitted to a **Hospital** or other health facility and for whom a room and

board charge has been made to receive diagnosis, treatment or other health services; and does not include a person who has received services in an Emergency Room, except when the **Hospital** admission is within 24 hours of an Emergency Room visit.

Insured

a person who is eligible for coverage under this Certificate as a **Certificateholder** [or as a **Dependent**], is enrolled, and for whom **Premium** is paid.

Lifetime Maximum

the dollar limitation on **Benefits** that will be paid for **You** during **Your** lifetime while covered under this Certificate.

Medically Necessary

any services or supplies provided for the diagnosis and treatment of a specific **Injury**, which are:

- a. ordered or recommended by a **Physician**;
- b. required for the treatment or management of a medical condition or symptom;
- c. the most appropriate supply or level of service which can safely be provided to **You**;
- d. provided in accordance with approved and generally accepted medical or surgical practice;
- e. not for the convenience of **You**, **Your Physician**, or another **Provider**;
- f. Not for services or supplies which are **Experimental or Investigational**;
- g. necessary for detoxification as an emergency medical condition provided **You** are not yet enrolled in other chemical treatment; and
- h. furnished in the least intensive type of medical care setting required by **Your** condition.

Services and supplies will **not** automatically be considered **Medically Necessary** because a **Physician** ordered them.

Nurse

any one of the following who is not a member of the **Insured's** immediate family or employed by the **Hospital** where the **Insured** is **Confined**:

- a. Licensed Practical Nurse (L.P.N.); or
- b. Licensed Vocational Nurse (L.V.N.); or
- c. graduated Registered Nurse (R.N).

Outpatient

Group Accident Certificate of Coverage [012345] an individual who receives health care services where he is not admitted to a **Hospital**.

Physician

a duly licensed member of a medical profession who:

- a. has an M.D. or D.O. degree;
- b. is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- c. provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- a. is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- b. provides medical services which are within the scope of his or her license or certificate;
- c. under applicable insurance law is considered a "physician" for purposes of this coverage;
- d. has the medical training and clinical expertise suitable to treat your condition;
- e. specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- f. a physician is not you or related to you.

Policy

the Group Accident Policy of which this Certificate forms a part that is issued to the **Policyholder**.

Policy Anniversary

the date twelve months after the date of the **Policyholder's Effective Date of Coverage** under the **Policy**, or as indicated on Summary of Benefits listed in this Certificate.

Policyholder

the entity named on the Application and the **Summary of Benefits**, who has applied for coverage under the **Policy**.

Premium

the dollar amount shown on the Schedule of **Premium Rates** page and amount paid by the **Policyholder** and/or **You** to keep the **Policy** in force.

Provider

any **Physician**, health professional, **Hospital**, **Nursing Facility**, home health agency or other person or recognized entity licensed to provide service for **Hospital** or medical services to **Insureds** covered under this **Policy**.

Rate

the pricing factor upon which the **Policyholder's** and/or **Your Premium** is based.

Reinstatement

the resumption of coverage that has lapsed under the **Policy**.

Renewal

continuance of coverage under the **Policy** beyond its original term by **Our** acceptance of the **Premium** for a new **Policy** term.

Rider

a document that modifies this **Policy**, and becomes part of this Certificate, also known as an **Amendment** or **Endorsement**.

Service Waiting Period

the length of time as specified in the **Summary of Benefits You** must wait from **Your** date of employment or application for coverage, until **Your** coverage is effective.

Summary of Benefits

the pages of this Certificate, which list the **Benefits** selected by the **Policyholder** and **You**.

Totally Disabled/ Total Disability

Your inability to perform the substantial and material duties of **Your** occupation.

We/Us/Our/Company

Symetra Life Insurance Company.

Workers' Compensation

benefit payments to any eligible individual as required by state law for accidents or occupational disease arising out of or in connection with the individual's employment.

Certificateholder Eligibility

Eligible Certificateholders - Hours of Work Credit

Each **Certificateholder** of a **Policyholder** who meets all of the following conditions is eligible for coverage under this **Policy**:

- a. performing all the normal duties of his job at the normal place of business of the **Policyholder**;
- b. working in an eligible class; and
- c. has worked and been paid for at least the minimum required hours at the normal place of business of the **Policyholder**.

The Date You are Eligible for Coverage

You become eligible for coverage upon completion of the **Service Waiting Period**.

Effective Date of Your Coverage

In order to become covered under this **Policy**, **You** must first enroll in writing on a form approved by **Us** giving the information **We** require.

If **You** are not required to contribute to the cost of **Your** coverage, coverage will become effective on the first day of the month following the latest of the following dates:

- a. the date **Premium** is received; or
- b. the date following completion of the **Service Waiting Period**, if any.

If **You** are required to contribute to the cost of **Your** coverage, the date coverage begins will depend on the date **You** enroll for coverage. However, it will be the first day of the month following the latest of the following dates:

- a. the date **Premium** is received; or
- b. the date following completion of the **Service Waiting Period**, if any; or
- c. the date **You** enroll for coverage.

Late Enrollment

If **You** fail to enroll **Yourself** [or **Your** eligible **Dependents**] within 31 days of **Your** [or **Your** eligible **Dependent's**] original eligibility date, then **You** [or **Your** eligible **Dependent**] will not be eligible to enroll for coverage under this **Policy** until the **Policyholder's** next open enrollment, if any. In the case of no open enrollment, late enrollment will be at the discretion of the **Policyholder**.

Dependent Eligibility

Please Note: This may not apply to **You** or **Your** coverage. **Dependent** coverage only applies if it is listed on **Your** Summary of Benefits and Benefit Amounts.

Eligible Dependents

A **Dependent of Yours** is eligible for coverage under this **Policy** if:

- a. **You** are an **Insured** under this **Policy**;
- b. **You** are in a class that qualifies for **Dependent Benefits**;
- c. the **Dependent** is not covered as a **Certificateholder** under this **Policy**; and
- d. if both **You** and **Your** spouse or domestic partner is covered under this **Policy** as **Certificateholders**, either, but not both, may elect to cover children who are eligible **Dependents**.

Date a Dependent is Eligible for Coverage

A **Dependent** is eligible to be an **Insured** on the later of:

- a. the date **You** become eligible for **Certificateholder** coverage; or
- b. the date **You** acquire **Your** first **Dependent** to include a newborn or newly placed adopted child; or
- c. the first day of the month following the date **You** acquire a spouse or domestic partner.

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** by submitting an enrollment form with the "Dependent box" checked within 31 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. the date **Premium** is received; or
- b. the date **You** become eligible for **Dependent** coverage; or
- c. the date the person becomes a **Dependent**.

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. the date **Premium** is received; or
- b. the date **You** become eligible for **Dependent** coverage; or
- c. the date **You** enroll for **Dependent** coverage.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 31 days following the birth or adoption of such child. Coverage will continue beyond the 31 day period for that child, if:

- a. **You** notify **Us** in writing of the birth or adoption of such child; and

- b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 31 days of the date of birth or adoption.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent** child is **Confined** to a **Hospital** or other health care facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or health care facility.

]

Benefit Changes

Change in Amounts of Benefits

Any change in the amount of **Benefits** due to a change in **Your** class or status, will be effective on the first business day of the month following the month in which **You** work and are paid for the minimum required hours, if any, provided:

- a. **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business; and
- b. **You** make any required payment for the change to be effective.

Changes in amounts of **Benefits**, due to an **Amendment**, **Endorsement** or **Rider** to this **Policy** or the **Policyholder's** coverage under this **Policy**, will take effect for **You** on the **Effective Date** of the **Amendment**, **Endorsement** or **Rider**.

Benefits payable under this **Policy** will be based on the coverage in effect at the time the eligible expenses were incurred.

Change in Amounts of Coverage

Once **You** have made **Your Benefit** elections for a given year, **You** cannot change those elections until the **Policyholder's** next open enrollment. Increases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change provided. **You** are performing all the normal duties of **Your** job at your normal place of business.

Decreases in the amount of **Certificateholder** coverage are effective on the first of the month following the date of change, provided **You** are performing all the normal duties of **Your** job at the **Policyholder's** normal place of business.

Termination Provisions

Termination of Your Coverage

Your coverage will cease on the earlier of:

- a. the date this **Policy** is canceled;
- b. the date the **Policyholder's** coverage ceases under this **Policy**; or
- c. the last day of the month in which the first of the following occurs:
 - i. **Your** membership in an eligible class ceases;
 - ii. **Your** employment with the **Policyholder** ceases;
 - iii. **You** or the **Policyholder** cease **Premium** payments for **Your** coverage;
 - iv. **You** are pensioned or retired, as defined by the **Policyholder**;
 - v. the date **You** begin active duty in the armed forces.

In addition, if **You** are classified as an "Hourly **Certificateholder**" **Your** coverage will cease on the first day of the month following any month in which **Your Hours of Work Credit** fall below the required number of hours, as established by the **Policyholder**.

[Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

- a. the date this **Policy** is canceled;
- b. the date **Your** coverage ceases;
- c. the date **We** cancel all **Dependent** coverage under this **Policy**; or
- d. last day of the month in which the first of the following occurs:
 - i. **You** are no longer in a class eligible for **Dependent** coverage; or
 - ii. the **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked, falls below the minimum required hours.

With respect to the **Benefits** of this **Policy**, coverage will be continued for a **Dependent** child beyond the "limiting age," as defined in the definition of **Dependent**, as long as the child continues to be both:

- a. incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical incapacity; and
- b. primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** not more than 31 days after the date such **Dependent** attains the "limiting age" , as defined in the definition of **Dependent**, and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the "limiting age."]

Reinstatement

If **You** have ceased to be eligible for coverage **You** may qualify for **Reinstatement** within 90 days from the date **You** were last eligible. **You** will be reinstated and eligible for coverage on the first day of the calendar month following the month in which **You** work and are paid for the minimum required hours. If **You** do not qualify for **Reinstatement** within 90 days from the date **You** were last eligible, **You** will be treated as a new worker.

Continuation of Coverage

Under the conditions that follow, **Benefits** for **You** [and **Your** covered **Dependents**] may continue beyond the day coverage would otherwise cease under the “Benefit Changes” and “Termination Provisions” sections if the required **Premium** is paid and this **Policy** is in force for the **Policyholder** during the continuation period shown below.

Coverage under this **Policy** will end on the first day **You** begin work for pay or profit with another employer.

Your Coverage

In the following circumstances, employment will be deemed to continue as shown, or until the **Policyholder**, acting under rules that preclude individual selection, terminates **Your** employment:

Continuation Period

Cause of Absence	Period in which Employment is deemed to continue	Coverage
Illness or Injury	6 months	All coverages
Temporary Lay-Off	2 months	All coverages
Leave of Absence	2 months	All coverages

Upon written request from the **Policyholder**, **We** may agree in writing to continue **Your** coverage for situations other than those listed above.

[Dependent Coverage

If any of the situations above apply to **You**, **Dependent** coverage may continue until **Your** coverage ends.]

Accident Benefit

Benefits will be paid as shown in the **Summary of Benefits** for **Eligible Expenses** that are incurred as a result of an **Accident** that occurs while the **You** are covered under this **Policy**.

The expenses must be incurred:

- a. Within 52 weeks from the date of the **Accident**; and
- b. The first expense must be incurred within 60 days after the date of the **Accident**.

The combined expenses paid for Medical, Dental, Surgical, Inpatient Hospital, X-ray and Lab and Inpatient Prescription Drug Benefits will not exceed the maximum Benefit amount shown in the **Summary of Benefits**.

Services and supplies paid under this Benefit include:

Medical Benefits

Medical **Benefits** will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy** for services and supplies rendered or prescribed by a licensed **Physician** or other licensed healthcare provider practicing within the scope of their license for the following:

- a. **Nursing** services;
- b. **Physician's** office visits;
- c. **Hospital Emergency Room** visits;
- d. **Outpatient Hospital** visits;
- e. Urgent care visits;
- f. Chiropractic visits;
- g. Rehabilitation services.

Medical Benefits will not be provided for services or supplies for preventive care, including but not limited to routine physicals, general health exams, routine immunizations and vaccinations.

Dental Benefits

Dental **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** or licensed Dentist in connection with an **Accident** while **You** are covered under this **Policy**. Procedures include:

- a. A closed or open reduction of a fracture;
- b. Dislocation of the jaw; or
- c. **Injury** to **Your** natural teeth.

Exclusions and Limitations

Dental **Benefits** will not be provided:

- a. For tooth re-implantology not resulting from an **Accident**;
- b. For procedures, services, or supplies, which do not meet accepted standards of dental practice;
- c. For treatment initiated while not covered under this **Policy**.

Surgical Benefits

Surgical **Benefits** will be provided for **Eligible Expenses** incurred when rendered by a licensed **Physician** for surgical procedures performed in connection with an **Accident** while **You** are covered under this **Policy**.

Inpatient Hospital Benefits

Inpatient Hospital Benefits will be provided for **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**.

Inpatient Hospital Benefits will be paid only if all of the following are met:

- a. the **Insured** is **Confined** in a **Hospital**; and
- b. a charge is made for room and board; and
- c. the entire duration of such **Hospital Confinement** is recommended and approved by a **Physician**; and
- d. **Confinement** is the result of a non-occupational **Accident**; and
- e. the services and supplies are not excluded under the Exclusions and Limitations provision of this **Policy**.

X-ray and Laboratory Benefits

Diagnostic X-ray and Laboratory **Benefits** will be provided for:

- a. **Eligible Expenses** incurred in connection with an **Accident** while **You** are covered under this **Policy**; and
- b. when they are ordered or performed by a **Physician**.

Inpatient Prescription Drugs

Inpatient Prescription Drugs Benefits will be provided for **Eligible Expenses** incurred if:

- a. **You** are **Confined** in a **Hospital**; and
- b. the drugs are prescribed by a **Physician**; and
- c. the drugs are administered in the **Hospital** by a licensed healthcare provider, in connection with an **Accident** while **You** are covered under this **Policy**.

Claim Provisions

Notice of Claim

Written notice of **Claim** must be given to **Us** within 20 days after the date any **Injury** or loss occurs or begins. If such notice is not furnished within that 20-day period, a **Claim** will still be considered for payment and will not be denied or reduced due to the delay if it is shown that notice was given as soon as was reasonably possible.

Claim Forms

We will furnish forms for filing **Proof of Loss** after **We** receive the Notice of **Claim**. If such forms are not furnished within 15 days of receipt of the notice, the claimant will be deemed to have met with the terms of this provision of this **Policy** if he submits written **Proof of Loss** within the time set forth in the **Proof of Loss** provision.

Proof of Loss

Written proof of **Claim** must be given to **Us** within 90 days after the date of loss or treatment.

However, the **Claim** will not be denied or reduced if:

- a. It is not reasonably possible to give proof in that time; and
- b. Proof is submitted within 12 months from the date of loss or treatment.

This 12 month period will not apply when **You** are legally incapable of submitting proof. I

Proof of Loss means a **Claim** form or an itemized bill with ICD-9 Codes (or successor codes) from the healthcare provider sent to **Our Policy** administrator, before any **Benefits** may be paid under this **Policy**.

Time Payment of Claims

Benefits payable under this **Policy** for any loss other than loss for which this **Policy** provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Payment of Benefits

Benefits payable under this **Policy** will be paid directly to:

- a. **You**;
- b. **Your** legally appointed guardian if **You** are not legally able to accept such **Benefits**; or
- c. a **Provider** upon **Your** assignment.

Any payment made in good faith by **Us** fully discharges **Us** to the extent of that payment. Failure to honor an assignment to a **Provider** due to inadvertent error will not subject **Us** to double payment.

Physical Examination and Autopsy

We, at **Our** own expense, will have the right to have **You** examined as often as **We** may reasonably require while a **Claim** is pending, and to require an autopsy in the case of death, unless it is forbidden by law.

Claim Procedures

Filing of Claims

We are responsible for evaluating all benefit **Claims** under this **Policy**. In order to receive **Benefits You** or **Your Authorized Representative** must complete, sign and submit a written **Claim** on a form approved by **Us**. An “**Authorized Representative**” means a person **You** authorize in writing to act on **Your** behalf. A person given the **Claim** authority to act by court order will be recognized and may submit **Claims** on **Your** behalf. The **Claim** form must be received within 90 days following the receipt of treatment to which the **Claim** relates unless

- (a) it was not reasonably possible to file the **Claim** within such time; and
- (b) the **Claim** is filed as soon as possible and in no event (except in the legal incapacity of the claimant) later than 12 months after the date of the receipt of the treatment to which the **Claim** relates.

We will make a decision on **Your Claim** within a reasonable time after it is received but no later than 30 days after the receipt of the **Claim**. If more information is required due to circumstances beyond the **Our** control, the time period may be extended up to an additional 15 days. **You** will be notified of the extension before the expiration of the initial 30-day period. **We** have the right to secure independent medical advice and to require such other evidence as **We** deem necessary in order to decide **Your Claim**. If **We** deny **Your Claim** in whole or in part, **You** will receive a written notification setting forth the reasons for the denial within a reasonable time period, but no later than 30 days after receipt of the **Claim** unless a determination that an extension of time for processing is needed as described above.

Right to Appeal a Denied Claim

If **You** disagree with a decision on a **Claim**, **You** or **Your** representative may, within 180 days of receiving an initial denial notice (or within the selected time period above if **You** receive no response regarding **Your Claim**) submit a written request to:

[**Select Benefit Administrators**
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699]

- a. Include comments and questions in writing.
- b. Review documents that apply to **Your Claim**.

If **Your** written request for review is not received within 180 days of receiving a denial notice, **You** will forfeit **Your** right to an appeal.

Important Appeal Deadline

Failure to comply within the 180 day deadline may cause **You** to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

Your written appeal should state the reasons that **You** feel **Your Claim** should not have been denied. It should include any additional facts and/or documents that **You** feel support **Your Claim**. **You** may also ask additional questions or make comments and **You** may review pertinent documents.

Notification of Adverse Benefit Decision

We will review and make a decision regarding **Your** claim within a reasonable period but no later than 30 days after it is submitted and **We** will notify **You** in writing of **Our** decision. If the decision remains the same, a denial, **We** will specify the reason for the denial and upon request, specify the **Policy** provisions, protocol or guideline relied upon which the decision is based.

If **Your** coverage is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health coverage, other than that which is provided by governmental entities or churches), **You** have a right to file a lawsuit under Section 502(a) of ERISA to recover benefits due **You** at any point after completion of an appeal. **You** may have other legal rights and remedies available under state or federal law.

Claims Fiduciary

We are designated as the **Claims** fiduciary for **Benefits** provided under the **Policy**. **We** have full discretion and authority to determine eligibility for **Benefits** and to construe and interpret all terms and provisions of the **Policy**.

Preemption of State Law

If applicable state law requires **Us** to take action on a **Claim** or appeal in a shorter timeframe, the shorter period will apply.

Extension of Coverage Benefit

Extension of Coverage applies to all **Benefits** shown in the **Summary of Benefits** of this **Policy**. **This Extension of Coverage Benefit** applies only to loss of accident coverage under this Select Benefits **Accident Insurance Policy**.

You [and **Your Dependents**] may qualify to temporarily extend the accident **Benefits** of this **Policy** at group rates (Extension of Coverage) in certain situations where coverage would otherwise end. **You** may only extend the **Benefits** of said **Policy** which **You** [and/or **Your Dependents**] had immediately prior to the date coverage ended.

You may choose Extension of Coverage for **Yourself** [and any covered **Dependent**] if **You** lose **Your** group accident coverage because of a reduction in hours or termination of employment (for reasons other than gross misconduct). [If **You** are a covered spouse or domestic partner, or **Dependent** child of a **Certificateholder**, **You** may choose Extension of Coverage for **Yourself** if **You** lose group accident coverage for any of the following reasons (qualifying event):

- a. **Your** spouse or domestic partner dies;

Group Accident Certificate of Coverage [012345]

- b. **You** spouse's or domestic partner's or, if a dependent, **You** parent's employment ends (for reasons other than gross misconduct), or his hours are reduced;
- c. **You** or, or if a **Dependent**, **Your** parents' divorce or legally separate;
- d. **Your** spouse or domestic partner, or parent becomes entitled to Medicare; or

Covered **Dependent** children of a **Certificateholder** may continue coverage if they cease to qualify as **Dependents** under the group policy. **You** or **Your Dependent** are responsible for notifying the **Policyholder** when certain qualifying events occur. These events include divorce or legal separation and ceasing to qualify as a **Dependent** under the group plan.]

The **Policyholder** must be notified within 60 days of the later of:

- a. the event; or
- b. the date coverage would end because of the event.

You have 60 days to elect Extension of Coverage from the later of:

- a. the date **You** lose coverage due to the event; or
- b. the date the **Policyholder** informed **You** that **You** may choose Extension of Coverage.

If **You** do not choose Extension of Coverage, **Your** coverage under this policy with the **Policyholder** will end. If **You** choose Extension of Coverage, it will be identical to coverage **You** [and/or **Your Dependents**] had immediately prior to the date coverage ended.

If **You** elect Extension of Coverage, **You** must pay the full cost of coverage each month. **You** have the option to continue coverage for **Yourself** [and/or **Your** covered **Dependents**] for 18 months if **You** lose group accident coverage due to termination of employment or a reduction in hours. A longer coverage period may be available in case of disability. If the Social Security Administration determines that **You** [or a covered **Dependent** is] [are] disabled by the end of the first 60 days of Extension of Coverage following termination of employment, coverage for the disabled person [and all covered **Dependents**] may be extended for an additional 11 months up to a total of 29 months. [This same 11-month extension is provided to a disabled child if the child is born or placed for adoption during the Extension of Coverage period and the child is determined to be disabled within the first 60 days of Extension of Coverage]. In order to qualify for coverage extension, **You** must notify the **Policyholder** before the end of the 18-month Extension of Coverage period and provide a copy of the Social Security disability determination letter within 60 days of the determination date. [If, during the 18-month Extension of Coverage period, another qualifying event takes place, coverage may be extended for up to 36 months for covered **Dependents**. In no case will the total Extension of Coverage period exceed 36 months].

Extension of Coverage may be terminated for any of the following reasons:

- a. the **Policyholder** no longer provides group accident coverage to any **Certificateholders**;
- b. **You** do not pay the **Premium** for **Your** Extension of Coverage on time;
- c. **You** become covered under another group accident plan that does not include a preexisting condition exclusion or limitations on preexisting conditions you may have after the date of your Extension of Coverage election;
- d. **You** become entitled to Medicare after the date of **Your** Extension of Coverage election; or
- e. the person whose Social Security disability enabled the extended coverage is determined to have recovered.

If **You** have any questions about Extension of Coverage, contact the **Policyholder**.

Non-Duplication of Benefits

To avoid duplication of benefit payments to an **Insured**, **Benefits** under this **Policy** will be coordinated with benefits payable under the Select Benefits Group Indemnity Policy and Select Benefits Group Outpatient Prescription Drug Policy, if applicable.

Exclusions and Limitations

Whether or not these may be considered accidents, benefits will not be paid for any expense for services or supplies:

- a. for which there is no charges made which an insurer is required to pay;
- b. received after Termination of Coverage, except as provided under this **Policy**;
- c. received as a result of participation in any sport for pay or profit;
- d. received as a result of participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding;
- e. received as a result of participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
- f. received as a result of participation or driving in any organized scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
- g. for hernia repair, including complications;
- h. related to cosmetic surgery, except for reconstructive surgery on an injured part of the body;
- i. related to dental care, except as required on account of **Injury** resulting from an **Accident** while covered under this **Policy**;
- j. which are not **Medically Necessary**;
- k. for durable medical equipment;
- l. that are not approved or accepted as essential to the treatment of the **Injury** by any of the following:
 - i. the American Medical Association;
 - ii. the U.S. Surgeon General;
 - iii. Department of Public Health; or
 - iv. the National Institute of Health.
- m. for disease, **Illness**, or bacterial infection, except infection resulting directly from an **Accidental Injury**;
- n. for an **Injury** or **Illness** caused wholly or partly, directly or indirectly by:
 - i. declared or undeclared war or act of war;
 - ii. intentionally committing or attempting to commit an assault or felony;
 - iii. intentionally self-inflicted **Injury**, while sane or insane.
- o. any **Illness** or **Injury** covered by any **Worker's Compensation** Act or similar law.

Symetra Life Insurance
Company
777 108th Avenue NE,
Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

ARKANSAS AMENDATORY RIDER

Policy/Certificate LGC-10011P/LGC-10011C 10/11:

The Policy and Certificate to which this rider is attached is amended as follows:

INTRODUCTION, Policy, page 3 and Certificate of Coverage page 3, the following provision is added:

INTRODUCTION

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
1-800-426-7784

If we at Symetra Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804
1-800-852-5494

DEFINITIONS section, definition of Illness is deleted in its entirety and replaced with the following:

“Illness

- a. Physical sickness or disease; or
- b. A mental disorder; or
- c. Complications of pregnancy; or
- d. Premature birth; or
- e. Congenital abnormalities.”

DEPENDENT ELIGIBILITY section, Effective Date of Coverage section is deleted in its entirety and replaced with the following:

Effective Date of Dependent Coverage

In order for a **Dependent** to become an **Insured**, **You** must first enroll the **Dependent** by submitting an enrollment form with the Dependent box checked within 31 days of acquiring a new eligible **Dependent** for **Dependent** coverage giving the information **We** require.

If **You** are not required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. The date **Premium** is received; or
- b. The date **You** become eligible for **Dependent** coverage; or
- c. The date the person becomes a **Dependent**.

If **You** are required to contribute to the cost of **Dependent** coverage, **Dependent** coverage will become effective on the first day of the month following the latest of the following dates if the **Dependent** is not **Confined** on that date:

- a. The date **Premium** is received; or
- b. The date **You** become eligible for **Dependent** coverage; or
- c. The date **You** enroll for **Dependent** coverage.

If **You** had elected **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided from the moment of birth or adoption of such child.

If **You** did not elect **Dependent** coverage before the birth or adoption of a child, **Dependent** coverage will be provided for the first 31 days following the birth or adoption of such child. Coverage will continue beyond the 31 day period for that child, if:

- a. **You** notify **Us** in writing of the birth or adoption of such child; and
- b. **You** authorize the **Policyholder** to make the required payroll deductions toward the cost of **Your Dependent** coverage within 90 days of the date of birth or adoption.

We require **You** to notify **Us** of additional **Dependents** to assure accurate **Claims** handling.

If a **Dependent** child is **Confined** to a **Hospital** or other health care facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the **Hospital** or health care facility.”

TERMINATION PROVISIONS section, Termination of Dependent Coverage section is deleted in its entirety and replaced with the following:

“Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

- a. The date this **Policy** is canceled;
- b. The date **Your** coverage ceases;
- c. The date **We** cancel all **Dependent** coverage under this **Policy**; or
- d. Last day of the month in which the first of the following occurs:
 - i. **You** are no longer in a class eligible for **Dependent** coverage; or
 - ii. The **Dependent** ceases to be an eligible **Dependent**.

In addition, coverage under this **Policy** will cease for a **Dependent** on the first day of the month following any month in which **Your** number of hours worked falls below the minimum required hours.

With respect to the **Benefits** and child **Premium Rates** of this **Policy**, coverage and the child **Premium Rates** will be continued for a **Dependent** child beyond the limiting age as long as the child continues to be both:

- a. Incapable of self-sustaining employment by reason of **Developmental Disability** and/or physical handicap; and
- b. Primarily dependent on **You** for support and maintenance.

Proof of such incapacity must be given to **Us** after the date such **Dependent** attains the limiting age and subsequently as required by **Us**, but not more often than once per year after the initial two year period from the date such **Dependent** attains the limiting age.

See "Continuation of Coverage" provisions for exceptions to Termination Provisions.

All other terms and conditions of the Policy remain unchanged.

Symetra Life Insurance Company

A handwritten signature in black ink that reads "George Pagos". The signature is written in a cursive, slightly slanted style.

George Pagos,

Secretary

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