

SERFF Tracking Number: AFDL-127094195 State: Arkansas  
Filing Company: American Public Life Insurance Company State Tracking Number: 48323  
Company Tracking Number: GDIS11APL  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: GDIS11APL Group Disability Income Policy  
Project Name/Number: APL Group STD Policy /GDIS11APL/C

## Filing at a Glance

Company: American Public Life Insurance Company

Product Name: GDIS11APL Group Disability Income Policy SERFF Tr Num: AFDL-127094195 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 48323

Sub-TOI: H11G.002 Short Term Co Tr Num: GDIS11APL State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Joelle Harbour Disposition Date: 03/28/2011  
Date Submitted: 03/23/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: APL Group STD Policy

Status of Filing in Domicile: Authorized

Project Number: GDIS11APL/C

Date Approved in Domicile: 03/07/2011

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust

Overall Rate Impact:

Filing Status Changed: 03/28/2011

State Status Changed: 03/28/2011

Deemer Date:

Created By: Joelle Harbour

Submitted By: Joelle Harbour

Corresponding Filing Tracking Number: GDIS11APL

Filing Description:

Based on the enclosed authorization, American Fidelity Assurance Company is submitting this form filing on behalf of American Public Life Insurance Company.

Submitted for review is form GDIS11APL group disability income policy and its corresponding certificate, GDIS11APLC. These forms are new and do not replace any previously approved forms. Form GDIS11APL provides coverage for group short-term disability income coverage.

Please note that bracketed information is variable or optional to allow for flexibility in designing plans, negotiating

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contracts with eligible groups, and to include variable fields for automated generation of policies and certificates. Although the policy includes variable and/or optional information, the actual text is not variable.

You will note in your examination that the certificate pages are written in first person language, while the policy is written in third person. Other than the face page, the language is virtually identical. We have completed the forms in a "John Doe" fashion to illustrate the manner in which the policy and certificate may be issued. This policy will be issued to employers, multiple employer trusts, and associations.

Any combination of pages of the policy or certificate form will produce a minimum Flesch Score of 50, excluding defined terms.

Domiciliary state approval was granted on March 7, 2011

Also enclosed for review is the group master application, AGM107, and the group insured application, A1269.

This policy also features a conversion option. The conversion policy has been filed under separate cover.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the state of Arkansas and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance in this matter. If you should have any questions or comments, or if you need any additional information, please feel free to contact me at 1-800-654-8489, extension 5997.

## Company and Contact

### Filing Contact Information

Joelle Harbour, Compliance Analyst I joelle.harbour@af-group.com  
2000 N Classen Blvd 405-523-5997 [Phone]  
Oklahoma City, OK 73106

### Filing Company Information

American Public Life Insurance Company CoCode: 60801 State of Domicile: Oklahoma  
2305 Lakeland Drive Group Code: 330 Company Type: LAH  
Flowood, MS 39232 Group Name: State ID Number:  
(601) 936-2157 ext. [Phone] FEIN Number: 64-0349942

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$200.00  
Retaliatory? No  
Fee Explanation: GDIS11APL-\$50  
GDIS11APLC-\$50  
A1269-\$50  
AGM107-\$50  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$200.00	03/23/2011	45907746

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/28/2011	03/28/2011

*SERFF Tracking Number:*      *AFDL-127094195*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Public Life Insurance Company*      *State Tracking Number:*      *48323*  
*Company Tracking Number:*      *GDIS11APL*  
*TOI:*                      *H11G Group Health - Disability Income*      *Sub-TOI:*                      *H11G.002 Short Term*  
*Product Name:*              *GDIS11APL Group Disability Income Policy*  
*Project Name/Number:*      *APL Group STD Policy /GDIS11APL/C*

## **Disposition**

Disposition Date: 03/28/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.



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## Form Schedule

### Lead Form Number: GDIS11APL

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/28/2011	GDIS11APL	Policy/Contract Certificate	Group Disability Income Policy	Initial		50.000	GDIS11APL_Standard.pdf
Approved-Closed 03/28/2011	GDIS11APLC	Certificate	Group Disability Income Certificate	Initial		50.000	GDIS11APLC_Standard.pdf
Approved-Closed 03/28/2011	AGM107	Application/Enrollment Form	Group Master Application	Initial		50.000	AGM107.pdf
Approved-Closed 03/28/2011	A1269	Application/Enrollment Form	Group Insured Application	Initial		45.000	A1269.pdf



# American Public Life Insurance Company

A member of the American Fidelity Group.

2305 Lakeland Drive, Flowood, Mississippi 39232

**POLICYHOLDER:** [ABC Industries]  
**ADDRESS:** [123 Main Street, Oklahoma City, Oklahoma, 73106]  
**EFFECTIVE DATE:** [June 1, 2011]  
**DATE OF ISSUE:** [June 1, 2011]  
**POLICY NUMBER:** [GDIS11-2T]  
**POLICY ANNIVERSARY DATE:** [June 1]

In consideration of:

- (a) the application of the Policyholder, a copy of which is attached to and made a part of this Policy; and
- (b) the payment of the first premium,

the Company agrees to pay the benefits of this Policy subject to all of its terms.

This Policy is executed by American Public Life Insurance Company as of its Date of Issue. This Policy will take effect on the Effective Date.

Jim Pate  
President

William F. Weems  
Vice President and C.A.O

## NON PARTICIPATING GROUP DISABILITY INCOME INSURANCE POLICY

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

FP

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TC

**SCHEDULE OF BENEFITS**

**PLAN: [1]**

**POLICYHOLDER:** [ABC Industries]

**POLICY NUMBER:** [GDIS11-27]

**EFFECTIVE DATE:** [June 1, 2011]

**ELIGIBILITY:** [All active permanent employees.]

**DISABILITY BENEFIT:**

[(1) Monthly amounts of the Disability Benefits are available [from any amount up to \$15,000] in [any amount up to \$100] increments. The Insured's Disability Benefit will be [any amount up to \$15,000], not to exceed [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 67%, 70%, 75%] of the Insured's Monthly Compensation. If applicable, the Insured's Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.] **OR**

[(2) [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 67%, 70%, 75%] of the Insured's Monthly Compensation not to exceed:

- (1) a maximum covered Monthly Compensation of [any amount up to \$26,250]; and
- (2) the amount for which premium is being paid.

If applicable, the Insured's Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.] **OR**

[(3) [The Monthly Disability Benefit is [any dollar amount up to \$15,000].]

**MINIMUM DISABILITY BENEFIT:**

[(1) [\$100, \$150, \$200]] **OR**

[(2) [10%, 15%, 20%, 25%] of the Insured's Monthly Disability Benefit] **OR**

[(3) [10%, 15%, 20%, 25%] of the Insured's Monthly Disability Benefit or [\$100, \$150, \$200] whichever is greater] **OR**

[(4) [10%, 15%, 20%, 25%, 30%, 35%, 50%] of the Insured's Monthly Disability Benefit for the first [90 days, 180 days, 210 days, 365 days] of Disability; after [90 days, 180 days, 210 days, 365 days] of Disability, the greater of [10%, 15%, 20%, 25%, 30%, 35%, 50%] of the Insured's Monthly Disability Benefit or [\$100, \$150, \$200]]

**MAXIMUM DISABILITY PERIOD:**

[(1) **Injury and/or Sickness:** [70 days, 77 days, 84 days, 90 days, 91 days, 98 days, 105 days, 120 days, 150 days, 180 days, 210 days, 14 months, 1 year, 2 years]]

**ELIMINATION PERIOD:**

Injury: [0 days, 3 days, 7 days, 14 days, 30 days, 60 days, 90 days, 100 days, 150 days, 180 days, 210 days][or after the end of accumulated sick leave, whichever is greater] **OR**

[[7 days, 14 days, 30 days], work-related 60 days]

Sickness: [0 days, 3 days, 7 days, 14 days, 30 days, 60 days, 90 days, 100 days, 150 days, 180 days, 210 days][or after the end of accumulated sick leave, whichever is greater] **OR**

[[7 days, 14 days, 30 days], work-related 60 days]

**[MAXIMUM MENTAL ILLNESS PERIOD:** Up to [3 months, 6 months, 1 year] not to exceed the Maximum Disability Period]

**[SPECIAL CONDITIONS PERIOD:** 1 year not to exceed the Maximum Disability Period.]

**[ACCIDENTAL DEATH BENEFIT:** [10 times the Disability Benefit] **OR** [\$10,000, \$20,000, \$25,000, \$50,000, \$75,000, \$100,000]]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:** [10 times the Disability Benefit] **OR** [\$10,000, \$20,000, \$25,000, \$50,000, \$75,000, \$100,000]]

**[PHYSICIAN EXPENSE BENEFIT:**

Injury: [\$50, \$75, \$100, \$150, \$200, \$250] per Injury

Sickness: [\$25, \$50]]

**[ADJUSTMENT WITH SICK LEAVE OR OTHER SALARY OR WAGE CONTINUANCE PLAN (See Section 3) EXTENDING BEYOND THE FOLLOWING NUMBER OF CALENDAR DAYS OF DISABILITY:** [30 days, 60 days, 90 days, 180 days, 210 days] **OR** [30 days, 60 days, 90 days] or the day benefits begin]

SB

## SECTION 1 DEFINITIONS

**ACTIVE EMPLOYMENT** means that the Insured is:

- (a) doing in the usual manner all of the regular duties of his or her employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends him or her.

The Insured will be said to be on Active Employment on a day which is not a scheduled work day only if the Insured is not Disabled and would be able to perform in the usual manner all of the regular duties of his or her employment if it were a scheduled work day.

**CERTIFICATE** means the individual Certificate issued to the Insured. It describes the Insured's coverage under the Policy.

**[DISABILITY (or Disabled)** means the Insured is unable to perform the material and substantial duties of his or her Regular Occupation.]

**[DISABILITY (or Disabled)** means the Insured is unable to perform the material and substantial duties of his or her Regular Occupation. The Insured is not considered Disabled if the Insured is unable to perform the duties of his or her Regular Occupation solely as a result of the loss of a professional license, occupational license, or certification.]

**DISABILITY PAYMENT** means the Insured's Disability Benefit minus any Deductible Sources of Income as outlined in Section 3.

**EFFECTIVE DATE** means the date described in the Policy. The date shown in the Insured's individual Certificate or Policy will be the Insured's Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

**ELIMINATION PERIOD** means that period of time, which starts after the Insured's Effective Date of coverage, during which:

- (a) the Insured is Disabled; and
- (b) no Disability Benefits are payable.

**EMPLOYER** means the individual, company, corporation, or governmental entity where the Insured is on Active Employment and includes any division, subsidiary, or affiliated company named in the Policy.

**HOSPITAL** means a place that is licensed and operated pursuant to law which:

- (a) provides care and treatment for ill and injured persons on an inpatient basis;
- (b) provides facilities for medical, diagnostic and surgical care;
- (c) provides 24-hour-a-day nursing care by or under the supervision of a registered nurse; and
- (d) is supervised by a staff of one or more Physicians; or
- (e) is accredited by the Joint Commission on the Accreditation of Hospitals.

The term Hospital shall not include an institution used by the Insured as:

- (a) a place for rehabilitation;
- (b) a place for rest or for the aged;
- (c) a nursing or convalescent home;
- (d) a long term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**INJURY** means physical harm or damage to the body sustained by the Insured which:

- (a) results directly from an accidental bodily injury;
- (b) is independent of disease or bodily infirmity; and
- (c) takes place while the Insured's coverage is in force.

**INSURED** means a person whose coverage has been applied for and is in force under the terms of the Policy.

**[MONTHLY COMPENSATION** means:

- (a) for contracted employees, one-twelfth (1/12) of the Insured's contract salary through his or her Employer;  
or
- (b) for non-contracted employees, one-twelfth (1/12) of the Insured's annual salary through his or her Employer,

in effect on the date Disability began.

It excludes any additional compensation including but not limited to, overtime pay, weekend or summer work compensation, bus or other allowances, bonuses or district-funded fringe benefits.

If the Insured becomes Disabled while on an approved leave of absence, the Company will use the Insured's gross Monthly Compensation from his or her Employer in effect just prior to the date the Insured's absence began.]

**[MONTHLY COMPENSATION** means:

- (a) one-twelfth (1/12) of the Insured's annual salary through his or her Employer exclusive of overtime or bonus earnings; or
- (b) one-twelfth (1/12) of the preceding 12 months' salary through the Insured's Employer, if the Insured's salary is solely or partially based on commissioned sales, overtime, or bonus earnings.]

**PHYSICIAN** means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for the Insured's Sickness or Injury; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat the Insured's condition.

The term Physician does not include the Insured, an employee of the Employer, anyone related to the Insured by blood or marriage, or anyone living in the Insured's household.

**POLICY** means the Policy issued to the Policyholder that covers the Insured.

**POLICYHOLDER** means the association, Employer, labor union, or trustee who holds the Policy.

**REGULAR AND APPROPRIATE CARE** means:

- (a) the Insured personally visits a Physician as frequently as medically required, according to standard medical practice, to effectively manage and treat the Insured's disabling condition(s); and
- (b) the Insured is receiving appropriate treatment and care for the Insured's disabling condition(s), which conforms with standard medical practice, by a Physician whose specialty or experience is the most appropriate for such disabling condition(s), according to standard medical practice.

**REGULAR OCCUPATION** means the occupation the Insured is routinely performing when his or her Disability begins. The Company will look at the Insured's occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

**SCHEDULE OF BENEFITS** (or **Schedule**) means the benefit schedule set forth in the Policy or Certificate.

**SICKNESS** means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

DEF

**SECTION 2  
ELIGIBILITY AND EFFECTIVE DATE**

**[ELIGIBILITY**

All persons who:

- (a) are on Active Employment as employees of the Employer, or members or employees of a member of the Policyholder;
- (b) qualify as eligible Insureds as defined by the Employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

are eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

**EFFECTIVE DATE: WHEN COVERAGE BEGINS**

The Insured's coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date the Company approves the written application, if the Insured:

- (a) applies in writing on or before said Effective Date;
- (b) meets the Company's underwriting rules;
- (c) is on Active Employment, as defined in Section 1; and
- (d) has paid all applicable premiums due.

If the Insured is not on Active Employment due to an Injury or Sickness when his or her coverage would otherwise take effect, coverage will take effect on the first of the month following the date the Insured returns to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Disability that begins after the Effective Date of such change, subject to all the provisions of the Policy.

[Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.]

EFF-VOL]

**[ELIGIBILITY**

All persons who:

- (a) are on Active Employment as employees of the Employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Insureds as defined by the Employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

**EFFECTIVE DATE: WHEN COVERAGE BEGINS**

The Insured's coverage will begin on the date he or she becomes eligible if the Insured's Employer has paid all applicable premiums.

Any change in coverage will apply only to a Disability that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD]

**SECTION 3  
DISABILITY BENEFITS**

Disability Payments will be provided if the Insured furnishes Proof of Loss that he or she is Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

- (a) be due to a covered Injury or Sickness; and
- (b) begin while the Insured's coverage is in force.

Disability Payments will be provided for each period the Insured remains Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability Payment will be provided for any period in which the Insured is not under the Regular and Appropriate Care of a Physician.

Disability Payments will be provided for only one Disability when:

- (a) more than one Disability exists at the same time; or
- (b) a Disability results from two or more causes.

If any Disability Payment is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the Disability Benefit.

Disability will be considered to have begun on the date the Insured was seen and treated by a Physician following continuous cessation of work.

**SUCCESSIVE DISABILITIES** are those Disabilities which result from the same or related causes for which benefits are payable under the Policy and will be considered one period of Disability unless the Disabilities are separated by the Insured's return to:

- (a) Active Employment; or
- (b) any other Gainful Occupation,

for at least [3, 6] consecutive months. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

BEN

**[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

The Company will pay the Disability Benefit described in the Schedule.

BNMA]

**[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

For the first [month, 6 months, 12 months] the Insured is Disabled due to a covered Disability and not working, we will pay the Disability Benefit described in the Schedule.

After [1 month, 6 months, 12 months], the Insured's Disability Payment will be the lesser of:

- (a) the Disability Benefit described in the Schedule; or
- (b) [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 70%, 75%] of the Insured's Monthly Compensation less any Deductible Sources of Income the Insured receives or is entitled to receive.

BNMB]

**[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

The Insured's Disability Payment will be the lesser of:

- (a) the Disability Benefit described in the Schedule; or
- (b) [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 70%, 75%] of the Insured's Monthly Compensation less any Deductible Sources of Income the Insured receives or is entitled to receive.

BNMC]

## [DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include all of the following:

- (a) Other group disability income.
- (b) Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.
- (c) United States Social Security Act or similar plan or act, including any amounts due the Insured's dependent(s) on account of the Insured's Disability.
- (d) State Disability.
- (e) Unemployment compensation.

[(f), (g), (h)]

[Workers' Compensation law, occupational disease law or any similar act or law.]

[Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond the period stated in the Schedule.] **OR**

[Sick leave or other salary or wage continuance plans provided by the Employer.]

In the case of other group disability insurance which provides for a reduction of benefits payable under this group disability income policy, the Company's liability under this group disability income policy shall equal its pro rata share of the Disability Payment. The pro rata share shall be determined by dividing the Disability Payment by the total of the monthly benefit payable under all group disability income policies under which the Insured is entitled to receive benefits and multiplying that result by the Disability Payment.

If the Company determines that the Insured may qualify for benefits under items (b), (c) [, or (f)] listed above, the Company may estimate the amount of benefits the Insured may be entitled to receive.

The Insured's Disability Payment will not be reduced by the estimated amount if the Insured:

- (a) applies for benefits under items (b), (c)[, and/or (f)] listed above and submits proof of application to the Company; and
- (b) appeals any denial received to all administrative levels the Company feels are necessary; and,
- (c) signs the reimbursement agreement form, which states the Insured promises to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by the Company at the time the benefits are received.

If the Insured's Disability Payment has been reduced by an estimated amount, the Company will adjust the Disability Payment when proof is received:

- (a) of the amount awarded; or
- (b) that benefits have been denied and all appeals the Company feels necessary have been completed.

**REIMBURSEMENT OF OVERPAYMENT:** If the Insured receives a lump sum payment from a Deductible Source of Income for a period previously paid by the Company, any resulting overpayment made by the Company will be due to the Company on a lump sum basis.

**LUMP SUM RETIREMENT WITHDRAWALS:** If the Insured has the option of taking retirement benefits on a monthly basis but chooses to receive retirement benefits on a lump sum basis or withdraw the Insured's retirement contributions, the Company will assume the Insured is receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

**INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS:** The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Policy.

**MINIMUM DISABILITY BENEFIT:** The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule.

DSIJ

**[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND WORKING**

The Company will provide a Disability Payment if the Insured is Disabled and his or her monthly Disability Earnings, if any, are less than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury.

If the Insured is Disabled and his or her Disability Earnings are greater than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury, the Company will figure the Insured's payment as follows:

During the first 12 months of payments, while Disabled and working, the Insured's Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed [80%, 100%] of the Insured's Monthly Compensation.

If the Disability Earnings plus the gross Disability Benefit exceeds [80%, 100%] of the Insured's Monthly Compensation, the Disability Payment will be reduced by the amount exceeding [80%, 100%] of the Insured's Monthly Compensation.

After 12 months of payments, while Disabled and working, the Insured will receive payments based on the percentage of Monthly Compensation the Insured is losing due to his or her Disability computed as follows:

- (a) subtract the Insured's Disability Earnings from his or her Monthly Compensation;
- (b) divide the answer in item (a) by the Insured's Monthly Compensation. This is the Insured's percentage of lost earnings; and
- (c) multiply the Insured's Disability Payment by the answer in item (b).

The Company will stop payments and the Insured's claim will end, if at any time the Insured is no longer Disabled or if the Insured's Disability Earnings exceed 80% of his or her Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings the Insured receives while Disabled and working.

The Elimination Period cannot be satisfied with days the Insured is Disabled and working.

BENW1]

**[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND WORKING**

The Company will provide a Disability Payment if the Insured is Disabled and his or her monthly Disability Earnings, if any, are less than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury.

If the Insured is Disabled and his or her Disability Earnings are greater than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury, the Company will figure the Insured's payment as follows:

The Insured will receive payments based on the percentage of Monthly Compensation the Insured is losing due to his or her Disability computed as follows:

- (a) subtract the Insured's Disability Earnings from his or her Monthly Compensation;
- (b) divide the answer in item (a) by the Insured's Monthly Compensation. This is the Insured's percentage of lost earnings; and
- (c) multiply the Insured's Disability Payment by the answer in item (b).

The Company will stop payments and the Insured's claim will end, if at any time the Insured is no longer Disabled or if the Insured's Disability Earnings exceed 80% of his or her Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings the Insured receives while Disabled and working.

The Elimination Period cannot be satisfied with days the Insured is Disabled and working.

BENW2]

## **[IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND WORKING**

The Company will provide a Disability Payment if the Insured is Disabled and his or her Monthly Disability Earnings, if any, are less than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury.

If the Insured is Disabled and his or her Disability Earnings are greater than 20% of the Insured's Monthly Compensation due to the same Sickness or Injury, the Company will figure the Insured's payment as follows:

The Insured's Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed 100% of the Insured's Monthly Compensation.

If the Disability Earnings plus the gross Disability Benefit exceeds 100% of the Insured's Monthly Compensation, the Disability Payment will be reduced by the amount exceeding the Insured's Monthly Compensation.

The Company will stop payments and the Insured's claim will end, if at any time the Insured is no longer Disabled or if the Insured's Disability Earnings exceed 80% of his or her Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings the Insured receives while Disabled and working.

The Elimination Period cannot be satisfied with days the Insured is Disabled and working.

BENW3J

## **TERMINATION OF BENEFITS**

Disability Payments will end on the earliest of these dates:

- (a) the date the Insured is no longer Disabled;
- (b) the date the Insured's Disability Earnings are more than 80% of the Insured's Monthly Compensation; Disability Earnings means the gross monthly earnings the Insured receives while Disabled and Working;
- (c) the date the Insured dies;
- (d) the last day Disability Payments are made according to the Schedule;
- (e) the date the Insured fails to provide the Company with written proof of his or her Disability, satisfactory to the Company;
- (f) the date the Insured ceases to be under the Regular and Appropriate Care of a Physician, refuses to undergo an examination by a Physician, or refuses vocational testing when the Company requires such examination or testing;
- (g) the date the Insured refuses to receive medical treatment that is generally acknowledged by Physicians to cure or improve the Insured's condition so as to reduce its disabling effect;
- (h) the date the Insured refuses to try or attempt to work with the assistance of:
  - (1) modifications made to the Insured's work environment, functional job elements or work schedule; or
  - (2) adaptive equipment or devices,

that a Physician has indicated will allow a return to the Insured's own occupation and which accommodations are approved by the Insured's Employer.

TERMBEN

**[PHYSICIAN EXPENSE BENEFIT**

If the Insured receives personal treatment by a Physician due to an Injury [or Sickness], the Physician Expense Benefit shown in the Schedule will be paid if a claim for no other benefit is made under the Policy.

[This benefit will be paid for Sickness only if the treatment is received during one full day of Disability during which the Insured missed one full day of work.]

[To be eligible for more than one payment for the same or related condition, the Insured must have returned to Active Employment for at least 14 consecutive scheduled workdays.]

[This benefit will be limited to [4, 6, 8] payments per calendar year.]

PHYJ

**[ACCIDENTAL DEATH BENEFIT**

The Accidental Death Benefit stated in the Schedule will be paid if:

- (a) the Insured dies as the direct result of an Injury; and
- (b) death occurs within [90 days, 180 days, 365 days] after the date of the Injury.

If the Insured dies and the Accidental Death Benefit applies, such benefit will be increased 1% for each full month that the Insured's Certificate was continuously in force just prior to death. The total increase shall not be more than 60%.

ADJ

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

If the Insured dies and the Accidental Death and Dismemberment Benefit applies, such benefit will be increased 1% for each full month that the Insured's Certificate was continuously in force just prior to death. The increase shall not be more than 60%.

If the Insured suffers loss of life, sight or limbs due to an Injury, an Accidental Death and Dismemberment Benefit, as stated in the Schedule, will be paid for such loss if the following conditions are met:

- (a) the loss must result directly from an Injury;
- (b) the loss must occur within [90 days, 180 days, 365 days] after the date of the Injury; and
- (c) the loss must not be excluded under the Exclusions Section.

The benefit amount payable for a loss which meets the conditions stated above is as follows:

For Loss of Life.....	100% of the Accidental Death and Dismemberment Benefit
For Loss of One Hand.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Foot.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Eye.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of more than one of the above in any one Injury.....	100% of the Accidental Death and Dismemberment Benefit
For Loss of Thumb and Index.....	25% of the Accidental Death and Dismemberment Finger on One Hand Benefit

"Loss" means, with regard to a hand or foot, actual severance through or above the wrist or ankle joints; with regard to an eye, entire or irrecoverable loss of sight; with regard to thumb and index finger on one hand, severance through or above the metacarpalphalangeal joints. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same Injury.

ADDJ

## **[SURVIVOR BENEFIT**

When the Company receives proof that the Insured has died, the Company will pay the Insured's Eligible Survivor a lump sum benefit equal to [2, 3, 6] times the Insured's Disability Payment, for which he or she was eligible for during the calendar month preceding death, if on the date of the Insured's death:

- (a) the Insured's Disability continued for [90, 150, 180] or more consecutive days; and
- (b) the Insured was receiving or was entitled to receive Disability Payments under the Policy.

If the Insured has no Eligible Survivor(s), no payment will be made.

**ELIGIBLE SURVIVOR** means the Insured's spouse, if living, otherwise the Insured's dependent children. ["Spouse" will include the Insured's domestic partner as defined by state or federal law.] Dependent children must be under age 25 and unmarried the day the Insured dies. The term dependent children includes a stepchild, adopted child, and foster child. A stepchild or foster child must be dependent on the Insured for support and maintenance.

## **ACCELERATED SURVIVOR BENEFIT**

The Insured may elect to receive the Survivor Benefit prior to his or her death if:

- (a) the Insured has a Terminal Illness; and
- (b) the Insured is receiving Disability Payments.

**TERMINAL ILLNESS** means a medical condition that with reasonable medical certainty is expected to result in the Insured's death within 12 months or less.

The Company will pay the Insured the Accelerated Survivor Benefit if the Insured:

- (a) elects this option in writing; and
- (b) provides written proof from a licensed Physician that the Insured has a Terminal Illness.

The Insured will not be eligible for the Accelerated Survivor Benefit if:

- (a) the Insured is required by law to elect this option in order to meet the claims of creditors, whether in bankruptcy or otherwise; or
- (b) the Insured is required by a government agency to elect an early payment in order to apply for, obtain, or keep a government benefit or entitlement.

The Insured may elect the Accelerated Survivor Benefit only once during the Insured's lifetime. If the Insured elects to receive the Accelerated Survivor Benefit prior to his or her death, no Survivor Benefit will be paid upon the Insured's death.

SURV-ACC]

### **[WAIVER OF PREMIUM**

If the Insured becomes Disabled due to a covered Injury or Sickness and is eligible to receive a Disability Payment, the Insured's insurance will be continued without payment of premium. Waiver of Premium will begin the first of the month following:

- (a) the Insured's satisfaction of the Elimination Period; or
- (b) [30 days, 60 days, 90 days, 180 days] of continuous Disability,

whichever is later, provided premium has been paid from the beginning of Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until:

- (a) the end of the Insured's Disability;
- (b) the end of the Maximum Benefit Period;
- (c) the date the Insured is no longer eligible to receive a Disability Payment;
- (d) the date the Policy terminates; or
- (e) the date the Insured's employment with the Policyholder or subscribing Employer unit ends,

whichever first occurs. The Company will require proof on an annual basis that the Insured remains Disabled during said period.

WPJ

### **[WAIVER OF PREMIUM DURING A STRIKE OR LOCKOUT**

If the Insured is not on Active Employment and he or she:

- (a) participates in a lawful strike authorized by the Insured's union; or
- (b) is locked out as the result of a labor dispute between the Insured's union and the Insured's Employer; and

the strike or lockout has lasted 30 consecutive days, the Company will waive the Insured's premium payments beginning on the next premium due date if the strike or lockout continues.

The Insured's eligibility will be maintained and premium will be waived if:

- (a) the Insured was on Active Employment and covered under the Policy before the strike or lockout began; and
- (b) the Company receives written proof from the Insured or the Insured's labor union that the strike or lockout meets the conditions stated above.

If the Insured becomes Disabled while on strike or lockout and the Insured's Disability continues beyond the date of the Insured's scheduled return to Active Employment, benefits will become payable after satisfaction of the Elimination Period provided premiums have been waived under this provision for the duration of the strike or lockout and the Insured resumes premium payments upon his or her scheduled return to Active Employment. The Elimination Period will begin with the date of the Insured's scheduled return to Active Employment following the strike or lockout period.

The Insured must notify the Company when:

- (a) the strike or lockout is resolved;
- (b) the Insured has returned to Active Employment;
- (c) the Insured is offered the opportunity to return to work for his or her Employer; or
- (d) the Insured's employment is terminated.

After the strike or lockout has ended, the Insured may continue his or her insurance by resuming payments on the first premium due date on or after the Insured returns to Active Employment. If premium payment is not resumed, the Insured's insurance will terminate on the last day of the period for which premium has been paid.

If the strike or lockout continues beyond [6 months, 12 months], Waiver of Premium will end and the Insured's coverage will terminate.

**RE-ENROLLMENT AFTER STRIKE OR LOCKOUT:** If the Insured is not on Active Employment due to a strike or lockout and his or her insurance terminates, the Insured may re-enroll for coverage not to exceed the amount previously held without furnishing evidence of good health provided the Insured submits a new enrollment application within 30 days of the Insured's return to Active Employment.

WPS]

**SECTION 4**  
**[LIMITATIONS AND EXCLUSIONS]**  
**[EXCLUSIONS]**

**[MENTAL ILLNESS LIMITED BENEFIT**

If the Insured is Disabled due to a Mental Illness, Disability Payments will be provided for the Maximum Mental Illness Period shown in the Schedule if:

- (a) the Insured is under the Regular and Appropriate Care of a Physician; and
- (b) the Insured receives medical treatment (mental or medical examination alone will not be considered treatment) from either:
  - (1) a registered specialist in psychiatry;
  - (2) a Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
  - (3) a Physician, if in Our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

**MENTAL ILLNESS** means Disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as:

- (a) schizophrenia;
- (b) depression;
- (c) manic depressive or bipolar illness;
- (d) anxiety;
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke;
- (b) trauma;
- (c) viral infection;
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

MI]

**[SPECIAL CONDITIONS LIMITED BENEFIT**

If the Insured is Disabled due to a Special Condition and the Insured is under the Regular and Appropriate Care of a Physician, Disability Payments will be provided for the Special Conditions Period shown in the Schedule.

Special Conditions means:

- (a) Chronic Fatigue Syndrome.
- (b) Fibromyalgia.
- (c) Environmental allergic illness, including, but not limited to sick building syndrome and multiple chemical sensitivity.
- (d) Self-Reported Symptoms. Self-Reported Symptoms means the manifestations of the Insured's condition that the Insured tells his or her Physician that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of Self-Reported Symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- [(e) Any disease, disorder, accident or injury of the neck or back not resulting in hemiplegia, paraplegia, or quadriplegia;]

SP-CON]

**[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT**

If the Insured is Disabled due to alcoholism or drug addiction, a limited benefit of up to [15 days, 30 days, 90 days, 1 year] for each Disability will be paid. In no event will benefits be paid beyond the Maximum Disability Period shown in the Schedule. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Injury or Sickness, it will be covered the same as any other illness.

ALCJ

**[PRE-EXISTING CONDITION LIMITATION**

No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before the Insured has been continuously covered under the Policy for 12 months.

This provision will not apply if the Insured has:

- (a) gone treatment-free;
- (b) incurred no expense
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for [3, 6, 12] consecutive months after the Effective Date of coverage for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after the Insured has been continuously covered under the Policy for 12 months.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE1J

**[PRE-EXISTING CONDITION LIMITATION**

A limited benefit up to 1 month's Disability Benefit will be payable for Disability caused by or resulting from a Pre-Existing Condition. This provision will not apply if the Insured has:

- (a) gone treatment-free;
- (b) incurred no expense
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for [3, 6, 12] consecutive months after the Effective Date of coverage for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after the Insured has been continuously covered under the Policy for 12 months.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE2J

## **[PRE-EXISTING CONDITION LIMITATION**

If Disability is caused by or resulting from a Pre-Existing Condition and begins before the Insured has been continuously covered under the Policy for 12 months, no Disability Benefit will be payable.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE3]

**[PRE-EXISTING CONDITION** means a disease, Injury, Sickness, physical condition or mental illness for which the Insured has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the [90-day, 3-month, 6-month, 12-month, 24-month] period immediately before the Effective Date of the Insured's coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

PEDEF]

## **[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS**

For all employees who were insured by their current Employer's prior group disability carrier on the day preceding the Employer's Effective Date of coverage under this Policy and who became insured with American Public Life Insurance Company on the Employer's Effective Date of coverage under this Policy, coverage for Pre-Existing Conditions will be administered as follows:

If the Insured was not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group disability carrier, there would be no Pre-Existing Condition Limitation applied under the American Public Life plan. If the Insured was not eligible for benefits under the prior group disability carrier's plan because of a Pre-Existing Condition Limitation, the Insured would not be eligible for benefits under the American Public Life plan until such time as the Insured had satisfied the Pre-Existing Condition limitation described in the Policy. Credit will be given for any portion of time satisfied with the Insured's current Employer's prior group disability carrier provided the Insured replaced that coverage with American Public Life's insurance on the Effective Date. This provision applies only up to the amount of coverage the Insured held with the prior group disability carrier on the day preceding American Public Life's Effective Date. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group disability carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CC]

## **[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS**

For all employees who were insured by their current Employer's prior group disability carrier on the day preceding the Employer's Effective Date of coverage under this Policy and who became insured with American Public Life Insurance Company on the Employer's Effective Date of coverage under this Policy, coverage for Pre-Existing Conditions will be administered as follows:

If the Insured was not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group disability carrier, there would be no Pre-Existing Condition Limitation applied for a Disability Benefit up to [\$1,500, \$2,000, \$3,000, \$4,000, \$5,000] under the American Public Life. If the Insured was not eligible for benefits under the prior group disability carrier's plan because of a Pre-Existing Condition Limitation, the Insured would not be eligible for benefits under the American Public Life plan until such time as the Insured had satisfied the Pre-Existing Condition limitation described in the Policy. Credit will be given for any portion of time satisfied with the Insured's current Employer's prior group disability carrier provided the Insured replaced that coverage with American Public Life's insurance on the Effective Date. This provision applies only:

- (a) for a Disability Benefit up to [\$1,500, \$2,000, \$3,000, \$4,000, \$5,000] under the American Public Life plan; and
- (b) up to the Maximum Disability Period the Insured held with the prior group disability carrier on the day preceding American Public Life's Effective Date.

Any Disability Benefit exceeding this amount will be subject to the Pre-Existing Condition Limitation. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group disability carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CC1]

## **EXCLUSIONS**

The Policy does not cover any loss, fatal or non-fatal, which results from any of the following:

- (a) Intentionally self-inflicted Injury while sane or insane.
- (b) An act of war, declared or undeclared.
- (c) Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- (d) Committing a felony.
- (e) Penal incarceration. The Company will not pay benefits for Disability or any other loss during any period for which the Insured is incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
- [(f) [Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which the Insured is entitled to Workers' Compensation\*.

\*The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements that occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which the Insured is entitled to Workers' Compensation benefits.]

EXC

**SECTION 5  
TERMINATION OF INSURANCE**

The Insured's insurance coverage will end on the earliest of these dates:

- (a) the date the Insured does not meet the Eligibility requirements as defined in Section 2;
- (b) the date the Insured retires;
- (c) the date the Insured ceases to be on Active Employment as defined in Section 1, except as provided for under the Leave of Absence provision in this Section;
- (d) the end of the last period for which premium has been paid;
- (e) the date the Policy is discontinued; or
- (f) the date the Insured's employment terminates.

If:

- (a) the Insured's coverage ends as a result of his or her termination of Active Employment;
- (b) such termination is caused by an Injury or Sickness for which Disability Benefits would be payable; and
- (c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no effect on Disability Payments that began before such termination.

The Company may end the Insured's coverage if the Insured makes a fraudulent claim.

The Company or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

The Company may end the coverage of a subscribing Employer unit if fewer persons are insured than required by the Policyholder's application.

**LEAVE OF ABSENCE**

The Insured's coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by the Insured's Employer.

TOI

**[CONVERSION OPTION**

If the Insured ends his or her employment the Insured may be eligible to continue coverage under the Company's group conversion policy. The Insured is eligible to apply for conversion coverage if:

- (a) the Insured has been continuously covered under the Policy for at least 12 consecutive months prior to the date his or her employment terminated;
- (b) the Insured is not Disabled;
- (c) the Insured is not covered under any other group disability income plan;
- (d) the Insured is employed and working at least 25 hours per week, excluding self-employment, on the date his or her conversion coverage becomes effective;
- (e) the Insured is not on a leave of absence;
- (f) the Insured's employment was not terminated due to retirement; and
- (g) the Insured is less than age 70.

The Insured must apply for conversion coverage and pay the first premium within 30 days after the date the Insured's employment ends. Coverage will be issued without evidence of insurability. To receive a group conversion application please contact the Company's office.

Upon receipt of the Insured's application and premium payment, a Certificate will be issued to the Insured. The conversion policy may not provide the same coverage the Insured had under his or her Employer's plan. The Insured's Disability Benefit under the conversion policy will not be greater than the Disability Benefit under this plan when his or her coverage ended.

CONV]

**SECTION 6**  
**PREMIUM CALCULATION AND PAYMENT**

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before the Insured's Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) the Company's Home Office; or
- (b) an authorized entity of the Company.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases the Company's liability, premium rates may be changed on the date the liability is increased.

**LATE FEES**

The Company may, at its discretion, accept premium beyond the Grace Period and agree to continuation of coverage. Any payments accepted by the Company beyond the Grace Period will be subject to a late fee of 1% of the total delinquent payment for each month due beyond the Grace Period.

PREM

**SECTION 7  
GENERAL PROVISIONS**

**ENTIRE CONTRACT-CHANGES:** The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) the Insured's application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to the Insured.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Insured's Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Disability (as defined in the Policy) that starts after such 2-year period.

**GRACE PERIOD:** A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to the Company, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

**NOTICE OF CLAIM:** Written Notice of Claim must be given to the Company at 2305 Lakeland Drive, Flowood, Mississippi 39232,, or to the Company's agent. Such Notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give Notice within that time, the claim may not be denied or reduced due to the delay.

**PROOF OF LOSS:** Proof of Loss must be given to the Company within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at the Insured's expense, must show:

- (a) that the Insured is under the Regular and Appropriate Care of a Physician;
- (b) the date the Insured's Disability began;
- (c) the cause of the Insured's Disability;
- (d) the appropriate documentation of the Insured's Monthly Compensation;
- (e) the extent of the Insured's Disability, including restrictions and limitations preventing the Insured from performing his or her Regular Occupation; and
- (f) the name and address of any Hospital or institution where the Insured received treatment, including all attending Physicians.

**CLAIM FORMS:** Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

**TIME OF PAYMENT OF CLAIMS:** All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written Proof. Benefits for any other covered loss will be paid as soon as the Company receives written proof of such Proof of Loss.

**PAYMENT OF BENEFITS:** All benefits will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to the Insured's beneficiary or estate. If a benefit is to be paid to the Insured's estate, or to the Insured and the Insured is not competent to give a valid release, the Company may pay up to \$1,000 of such benefit to one of the Insured's relatives who are deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

**PHYSICAL EXAMINATION:** While a claim is pending, the Company has the right to have the Insured:

- (a) examined as often as is reasonably necessary. The Company will pay for such examination; and/or
- (b) interviewed by an authorized Company representative to determine the extent of any Sickness or Injury for which the Insured has made a claim. This right may be used as often as reasonably required.

**LEGAL ACTION:** No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

**CERTIFICATES:** An Individual Certificate will be issued to the Insured. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to the Insured, only the last one issued will be in effect.

**MISSTATEMENT OF FACTS:** If relevant facts regarding the Insured are not accurate:

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

**CONFORMITY WITH STATE LAWS:** A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

**CLAIM OVERPAYMENT:** The Company has the right to recover from the Insured any amount that the Company determines to be an overpayment. The Insured has the obligation to refund to the Company any such amount. The Company's rights and the Insured's obligations in this regard may also be set forth in the reimbursement agreement the Insured may be required to sign when he or she become eligible for benefits under this Policy.

If benefits are overpaid on any claim, the Insured must reimburse the Company within 30 days.

If reimbursement is not made in a timely manner, the Company has the right to:

- (a) recover such overpayments from:
  - (1) the Insured;
  - (2) any other person to or for whom payment was made;
  - (3) the Insured's estate;
  - (4) the Insured's beneficiary;
  - (5) any other organization; and
  - (6) any other insurance company;
- (b) reduce or offset against any future benefits payable to the Insured, the Insured's Estate, the Insured's Survivors, or the Insured's Beneficiary, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- (c) refer the Insured's unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

GENPROV



# American Public Life Insurance Company

A member of the American Fidelity Group.

2305 Lakeland Drive, Flowood, Mississippi 39232

## CERTIFICATE OF INSURANCE

American Public Life Insurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see ELIGIBILITY on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

Jim Pate  
President

William F. Weems  
Vice President and C.A.O

## NON PARTICIPATING GROUP DISABILITY INCOME INSURANCE CERTIFICATE

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

FP

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**SCHEDULE OF BENEFITS**

**PLAN: [1]**

**POLICYHOLDER:** [ABC Employer Group]

**POLICY NUMBER:** [DIS11-A]

**CERTIFICATE EFFECTIVE DATE:** [June 1, 2011]

**ELIGIBILITY:** [All active permanent employees.]

**DISABILITY BENEFIT:**

**[(1)** Monthly amounts of the Disability Benefits are available [from any amount up to \$15,000] in [any amount up to \$100] increments. Your Disability Benefit will be [any amount up to \$15,000], not to exceed [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 67%, 70%, 75%] of Your Monthly Compensation. If applicable, Your Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.] **OR**

**[(2)** [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 67%, 70%, 75%] of Your Monthly Compensation not to exceed:

- (1) a maximum covered Monthly Compensation of [any amount up to \$26,250]; and
- (2) the amount for which premium is being paid.

If applicable, Your Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.] **OR**

**[(3)** [The Monthly Disability Benefit is [any dollar amount up to \$15,000].]

**MINIMUM DISABILITY BENEFIT:**

**[(1)** [\$100, \$150, \$200]] **OR**

**[(2)** [10%, 15%, 20%, 25%] of Your Monthly Disability Benefit] **OR**

**[(3)** [10%, 15%, 20%, 25%] of Your Monthly Disability Benefit or [\$100, \$150, \$200] whichever is greater] **OR**

**[(4)** [10%, 15%, 20%, 25%, 30%, 35%, 50%] of Your Monthly Disability Benefit for the first [90 days, 180 days, 210 days, 365 days] of Disability; after [90 days, 180 days, 210 days, 365 days] of Disability, the greater of [10%, 15%, 20%, 25%, 30%, 35%, 50%] of Your Monthly Disability Benefit or [\$100, \$150, \$200]]

**MAXIMUM DISABILITY PERIOD:**

**Injury and/or Sickness:** [70 days, 77 days, 84 days, 90 days, 91 days, 98 days, 105 days, 120 days, 150 days, 180 days, 210 days, 14 months, 1 year, 2 years]]

**ELIMINATION PERIOD:**

**Injury:** [0 days, 3 days, 7 days, 14 days, 30 days, 60 days, 90 days, 100 days, 150 days, 180 days, 210 days][or after the end of accumulated sick leave, whichever is greater] **OR**

[[7 days, 14 days, 30 days], work-related 60 days]

**Sickness:** [0 days, 3 days, 7 days, 14 days, 30 days, 60 days, 90 days, 100 days, 150 days, 180 days, 210 days][or after the end of accumulated sick leave, whichever is greater] **OR**

[[7 days, 14 days, 30 days], work-related 60 days]

**[MAXIMUM MENTAL ILLNESS PERIOD:** Up to [3 months, 6 months, 1 year] not to exceed the Maximum Disability Period]

**[SPECIAL CONDITIONS PERIOD:** 1 year not to exceed the Maximum Disability Period.]

**[ACCIDENTAL DEATH BENEFIT:** [10 times the Disability Benefit] **OR** [\$10,000, \$20,000, \$25,000, \$50,000, \$75,000, \$100,000]]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:** [10 times the Disability Benefit] **OR** [\$10,000, \$20,000, \$25,000, \$50,000, \$75,000, \$100,000]]

**[PHYSICIAN EXPENSE BENEFIT:**

[Injury: [\$50, \$75, \$100, \$150, \$200, \$250] per Injury]

[Sickness: [\$25, \$50]]]

**[ADJUSTMENT WITH SICK LEAVE OR OTHER SALARY OR WAGE CONTINUANCE PLAN (See Section 3) EXTENDING BEYOND THE FOLLOWING NUMBER OF CALENDAR DAYS OF DISABILITY:** [30 days, 60 days, 90 days, 180 days, 210 days] **OR** [30 days, 60 days, 90 days] or the day benefits begin]

SB

## **SECTION 1 DEFINITIONS**

**ACTIVE EMPLOYMENT** means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not Disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

**CERTIFICATE** means the individual Certificate issued to You. It describes Your coverage under the Policy.

**[DISABILITY (or Disabled)** means You are unable to perform the material and substantial duties of Your Regular Occupation.]

**[DISABILITY (or Disabled)** means You are unable to perform the material and substantial duties of Your Regular Occupation. You are not considered Disabled if You are unable to perform the duties of Your Regular Occupation solely as a result of the loss of a professional license, occupational license, or certification.]

**DISABILITY PAYMENT** means Your Disability Benefit minus any Deductible Sources of Income as outlined in Section 3.

**EFFECTIVE DATE** means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

**ELIMINATION PERIOD** means that period of time, which starts after Your Effective Date of coverage, during which:

- (a) You are Disabled; and
- (b) no Disability Benefits are payable.

**EMPLOYER** means the individual, company, corporation, or governmental entity where You are on Active Employment and includes any division, subsidiary, or affiliated company named in the Policy.

**HOSPITAL** means a place that is licensed and operated pursuant to law which:

- (a) provides care and treatment for ill and injured persons on an inpatient basis;
- (b) provides facilities for medical, diagnostic and surgical care;
- (c) provides 24-hour-a-day nursing care by or under the supervision of a registered nurse; and
- (d) is supervised by a staff of one or more Physicians; or
- (e) is accredited by the Joint Commission on the Accreditation of Hospitals.

The term Hospital shall not include an institution used by You as:

- (a) a place for rehabilitation;
- (b) a place for rest or for the aged;
- (c) a nursing or convalescent home;
- (d) a long term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**INJURY** means physical harm or damage to the body sustained by You which:

- (a) results directly from an accidental bodily injury;
- (b) is independent of disease or bodily infirmity; and
- (c) takes place while Your coverage is in force.

**INSURED** means a person whose coverage has been applied for and is in force under the terms of the Policy.

**[MONTHLY COMPENSATION** means:

- (a) for contracted employees, one-twelfth (1/12) of Your contract salary through Your Employer; or
- (b) for non-contracted employees, one-twelfth (1/12) of Your annual salary through Your Employer,

in effect on the date Disability began.

It excludes any additional compensation including but not limited to, overtime pay, weekend or summer work compensation, bus or other allowances, bonuses or district-funded fringe benefits.

If You become Disabled while on an approved leave of absence, We will use Your gross Monthly Compensation from Your Employer in effect just prior to the date Your absence began.]

**[MONTHLY COMPENSATION** means:

- (a) one-twelfth (1/12) of Your annual salary through Your Employer exclusive of overtime or bonus earnings; or
- (b) one-twelfth (1/12) of the preceding 12 months' salary through Your Employer, if Your salary is solely or partially based on commissioned sales, overtime, or bonus earnings.]

**PHYSICIAN** means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your Sickness or Injury; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, an employee of the Employer, anyone related to You by blood or marriage, or anyone living in Your household.

**POLICY** means the Policy issued to the Policyholder that covers You.

**POLICYHOLDER** means the association, Employer, labor union, or trustee who holds the Policy.

**REGULAR AND APPROPRIATE CARE** means:

- (a) You personally visit a Physician as frequently as medically required, according to standard medical practice, to effectively manage and treat Your disabling condition(s); and
- (b) You are receiving appropriate treatment and care for Your disabling condition(s), which conforms with standard medical practice, by a Physician whose specialty or experience is the most appropriate for such disabling condition(s), according to standard medical practice.

**REGULAR OCCUPATION** means the occupation You are routinely performing when Your Disability begins. We will look at Your occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

**SCHEDULE OF BENEFITS (or Schedule)** means the benefit schedule set forth in the Policy or Certificate.

**SICKNESS** means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

DEF

**SECTION 2  
ELIGIBILITY AND EFFECTIVE DATE**

**[ELIGIBILITY**

All persons who:

- (a) are on Active Employment as employees of the Employer, or members or employees of a member of the Policyholder;
- (b) qualify as eligible Insureds as defined by the Employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

are eligible to be insured under the Policy. Evidence of insurability acceptable to Us may be required.

**EFFECTIVE DATE: WHEN COVERAGE BEGINS**

Your coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date We approve the written application, if You:

- (a) apply in writing on or before said Effective Date;
- (b) meet Our underwriting rules;
- (c) are on Active Employment, as defined in Section 1; and
- (d) have paid all applicable premiums due.

If You are not on Active Employment due to an Injury or Sickness when Your coverage would otherwise take effect, coverage will take effect on the first of the month following the date You return to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Disability that begins after the Effective Date of such change, subject to all the provisions of the Policy.

[Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.]

EFF-VOL]

**[ELIGIBILITY**

All persons who:

- (a) are on Active Employment as employees of the Employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Insureds as defined by the Employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

**EFFECTIVE DATE: WHEN COVERAGE BEGINS**

Your coverage will begin on the date You become eligible if Your Employer has paid all applicable premiums.

Any change in coverage will apply only to a Disability that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD]

**SECTION 3  
DISABILITY BENEFITS**

Disability Payments will be provided if You furnish Proof of Loss that You are Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

- (a) be due to a covered Injury or Sickness; and
- (b) begin while Your coverage is in force.

Disability Payments will be provided for each period You remain Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability Payment will be provided for any period in which You are not under the Regular and Appropriate Care of a Physician.

Disability Payments will be provided for only one Disability when:

- (a) more than one Disability exists at the same time; or
- (b) a Disability results from two or more causes.

If any Disability Payment is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the Disability Benefit.

Disability will be considered to have begun on the date You were seen and treated by a Physician following continuous cessation of work.

**SUCCESSIVE DISABILITIES** are those Disabilities which result from the same or related causes for which benefits are payable under the Policy and will be considered one period of Disability unless the Disabilities are separated by Your return to:

- (a) Active Employment; or
- (b) any other Gainful Occupation,

for at least [3, 6] consecutive months. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

BEN

**[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

We will pay the Disability Benefit described in the Schedule.

BNMA]

**[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

For the first [month, 6 months, 12 months] You are Disabled due to a covered Disability and not working, we will pay the Disability Benefit described in the Schedule.

After [1 month, 6 months, 12 months], Your Disability Payment will be the lesser of:

- (a) the Disability Benefit described in the Schedule; or
- (b) [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 70%, 75%] of Your Monthly Compensation less any Deductible Sources of Income You receive or are entitled to receive.

BNMB]

**[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

Your Disability Payment will be the lesser of:

- (a) the Disability Benefit described in the Schedule; or
- (b) [20%, 25%, 30%, 35%, 40%, 50%, 60%, 66 2/3%, 70%, 75%] of Your Monthly Compensation less any Deductible Sources of Income You receive or are entitled to receive.

BNMC]

## DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include all of the following:

- (a) Other group disability income.
- (b) Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.
- (c) United States Social Security Act or similar plan or act, including any amounts due Your dependent(s) on account of Your Disability.
- (d) State Disability.
- (e) Unemployment compensation.

[(f), (g), (h)]

[Workers' Compensation law, occupational disease law or any similar act or law.]

[Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond the period stated in the Schedule.] **OR**

[Sick leave or other salary or wage continuance plans provided by the Employer.]

In the case of other group disability insurance which provides for a reduction of benefits payable under this group disability income policy, Our liability under this group disability income policy shall equal its pro rata share of the Disability Payment. The pro rata share shall be determined by dividing the Disability Payment by the total of the monthly benefit payable under all group disability income policies under which You are entitled to receive benefits and multiplying that result by the Disability Payment.

If We determine that You may qualify for benefits under items (b), (c) [, or (f)] listed above, We may estimate the amount of benefits You may be entitled to receive.

Your Disability Payment will not be reduced by the estimated amount if You:

- (a) apply for benefits under items (b), (c)[, and/or (f)] listed above and submit proof of application to Us; and
- (b) appeal any denial received to all administrative levels We feel are necessary; and,
- (c) sign the reimbursement agreement form, which states You promise to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by Us at the time the benefits are received.

If Your Disability Payment has been reduced by an estimated amount, We will adjust the Disability Payment when proof is received:

- (a) of the amount awarded; or
- (b) that benefits have been denied and all appeals We feel necessary have been completed.

**REIMBURSEMENT OF OVERPAYMENT:** If You receive a lump sum payment from a Deductible Source of Income for a period previously paid by Us, any resulting overpayment made by Us will be due to Us on a lump sum basis.

**LUMP SUM RETIREMENT WITHDRAWALS:** If You have the option of taking retirement benefits on a monthly basis but choose to receive retirement benefits on a lump sum basis or withdraw Your retirement contributions, We will assume You are receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

**INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS:** The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Policy.

**MINIMUM DISABILITY BENEFIT:** The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule.

DSIJ

**[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING**

We will provide a Disability Payment if You are Disabled and Your monthly Disability Earnings, if any, are less than 20% of Your Monthly Compensation due to the same Sickness or Injury.

If You are Disabled and Your Disability Earnings are greater than 20% of Your Monthly Compensation due to the same Sickness or Injury, We will figure Your payment as follows:

During the first 12 months of payments, while Disabled and working, Your Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed [80%, 100%] of Your Monthly Compensation.

If the Disability Earnings plus the gross Disability Benefit exceeds [80%, 100%] of Your Monthly Compensation, the Disability Payment will be reduced by the amount exceeding [80%, 100%] of Your Monthly Compensation.

After 12 months of payments, while Disabled and working, You will receive payments based on the percentage of Monthly Compensation You are losing due to Your Disability computed as follows:

- (a) subtract Your Disability Earnings from Your Monthly Compensation;
- (b) divide the answer in item (a) by Your Monthly Compensation. This is Your percentage of lost earnings; and
- (c) multiply Your Disability Payment by the answer in item (b).

We will stop payments and Your claim will end, if at any time You are no longer Disabled or if Your Disability Earnings exceed 80% of Your Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings You receive while Disabled and working.

The Elimination Period cannot be satisfied with days You are Disabled and working.

BENW1]

**[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING**

We will provide a Disability Payment if You are Disabled and Your monthly Disability Earnings, if any, are less than 20% of Your Monthly Compensation due to the same Sickness or Injury.

If You are Disabled and Your Disability Earnings are greater than 20% of Your Monthly Compensation due to the same Sickness or Injury, We will figure Your payment as follows:

You will receive payments based on the percentage of Monthly Compensation You are losing due to Your Disability computed as follows:

- (a) subtract Your Disability Earnings from Your Monthly Compensation;
- (b) divide the answer in item (a) by Your Monthly Compensation. This is Your percentage of lost earnings; and
- (c) multiply Your Disability Payment by the answer in item (b).

We will stop payments and Your claim will end, if at any time You are no longer Disabled or if Your Disability Earnings exceed 80% of Your Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings You receive while Disabled and working.

The Elimination Period cannot be satisfied with days You are Disabled and working.

BENW2]

## **[IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING**

We will provide a Disability Payment if You are Disabled and Your Monthly Disability Earnings, if any, are less than 20% of Your Monthly Compensation due to the same Sickness or Injury.

If You are Disabled and Your Disability Earnings are greater than 20% of Your Monthly Compensation due to the same Sickness or Injury, We will figure Your payment as follows:

Your Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed 100% of Your Monthly Compensation.

If the Disability Earnings plus the gross Disability Benefit exceeds 100% of Your Monthly Compensation, the Disability Payment will be reduced by the amount exceeding Your Monthly Compensation.

We will stop payments and Your claim will end, if at any time You are no longer Disabled or if Your Disability Earnings exceed 80% of Your Monthly Compensation.

**DISABILITY EARNINGS** means the gross monthly earnings You receive while Disabled and working.

The Elimination Period cannot be satisfied with days You are Disabled and working.

BENW3]

## **TERMINATION OF BENEFITS**

Disability Payments will end on the earliest of these dates:

- (a) the date You are no longer Disabled;
- (b) the date Your Disability Earnings are more than 80% of Your Monthly Compensation; Disability Earnings means the gross monthly earnings You receive while Disabled and Working;
- (c) the date You die;
- (d) the last day Disability Payments are made according to the Schedule;
- (e) the date You fail to provide Us with written proof of Your Disability, satisfactory to Us;
- (f) the date You cease to be under the Regular and Appropriate Care of a Physician, refuse to undergo an examination by a Physician, or refuse vocational testing when We require such examination or testing;
- (g) the date You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effect;
- (h) the date You refuse to try or attempt to work with the assistance of:
  - (1) modifications made to Your work environment, functional job elements or work schedule; or
  - (2) adaptive equipment or devices,

that a Physician has indicated will allow a return to Your own occupation and which accommodations are approved by Your Employer.

TERMBEN

## **[PHYSICIAN EXPENSE BENEFIT**

If You receive personal treatment by a Physician due to an Injury [or Sickness], the Physician Expense Benefit shown in the Schedule will be paid if a claim for no other benefit is made under the Policy.

[This benefit will be paid for Sickness only if the treatment is received during one full day of Disability during which You missed one full day of work.]

[To be eligible for more than one payment for the same or related condition, You must have returned to Active Employment for at least 14 consecutive scheduled workdays.]

[This benefit will be limited to [4, 6, 8] payments per calendar year.]

PHY]

**[ACCIDENTAL DEATH BENEFIT**

The Accidental Death Benefit stated in the Schedule will be paid if:

- (a) You die as the direct result of an Injury; and
- (b) death occurs within [90 days, 180 days, 365 days] after the date of the Injury.

If You die and the Accidental Death Benefit applies, such benefit will be increased 1% for each full month that Your Certificate was continuously in force just prior to death. The total increase shall not be more than 60%.

ADJ

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

If You die and the Accidental Death and Dismemberment Benefit applies, such benefit will be increased 1% for each full month that Your Certificate was continuously in force just prior to death. The increase shall not be more than 60%.

If You suffer loss of life, sight or limbs due to an Injury, an Accidental Death and Dismemberment Benefit, as stated in the Schedule, will be paid for such loss if the following conditions are met:

- (a) the loss must result directly from an Injury;
- (b) the loss must occur within [90 days, 180 days, 365 days] after the date of the Injury; and
- (c) the loss must not be excluded under the Exclusions Section.

The benefit amount payable for a loss which meets the conditions stated above is as follows:

For Loss of Life.....	100% of the Accidental Death and Dismemberment Benefit
For Loss of One Hand.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Foot.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Eye.....	50% of the Accidental Death and Dismemberment Benefit
For Loss of more than one of the above in any one Injury.....	100% of the Accidental Death and Dismemberment Benefit
For Loss of Thumb and Index.....	25% of the Accidental Death and Dismemberment Finger on One Hand Benefit

“Loss” means, with regard to a hand or foot, actual severance through or above the wrist or ankle joints; with regard to an eye, entire or irrecoverable loss of sight; with regard to thumb and index finger on one hand, severance through or above the metacarpalphalangeal joints. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same Injury.

ADDJ

**[SURVIVOR BENEFIT**

When We receive proof that You have died, We will pay Your Eligible Survivor a lump sum benefit equal to [2, 3, 6] times Your Disability Payment, for which You were eligible for during the calendar month preceding death, if on the date of Your death:

- (a) Your Disability continued for [90, 150, 180] or more consecutive days; and
- (b) You were receiving or were entitled to receive Disability Payments under the Policy.

If You have no Eligible Survivor(s), no payment will be made.

**ELIGIBLE SURVIVOR** means Your spouse, if living, otherwise Your dependent children. [“Spouse” will include Your domestic partner as defined by state or federal law.] Dependent children must be under age 25 and unmarried the day You die. The term dependent children includes a stepchild, adopted child, and foster child. A stepchild or foster child must be dependent on You for support and maintenance.

## **ACCELERATED SURVIVOR BENEFIT**

You may elect to receive the Survivor Benefit prior to Your death if:

- (a) You have a Terminal Illness; and
- (b) You are receiving Disability Payments.

**TERMINAL ILLNESS** means a medical condition that with reasonable medical certainty is expected to result in Your death within 12 months or less.

We will pay You the Accelerated Survivor Benefit if You:

- (a) elect this option in writing; and
- (b) provide written proof from a licensed Physician that You have a Terminal Illness.

You will not be eligible for the Accelerated Survivor Benefit if:

- (a) You are required by law to elect this option in order to meet the claims of creditors, whether in bankruptcy or otherwise; or
- (b) You are required by a government agency to elect an early payment in order to apply for, obtain, or keep a government benefit or entitlement.

You may elect the Accelerated Survivor Benefit only once during Your lifetime. If You elect to receive the Accelerated Survivor Benefit prior to Your death, no Survivor Benefit will be paid upon Your death.

SURV-ACC]

## **[WAIVER OF PREMIUM**

If You become Disabled due to a covered Injury or Sickness and are eligible to receive a Disability Payment, Your insurance will be continued without payment of premium. Waiver of Premium will begin the first of the month following:

- (a) Your satisfaction of the Elimination Period; or
- (b) [30 days, 60 days, 90 days, 180 days] of continuous Disability,

whichever is later, provided premium has been paid from the beginning of Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until:

- (a) the end of Your Disability;
- (b) the end of the Maximum Benefit Period;
- (c) the date You are no longer eligible to receive a Disability Payment;
- (d) the date the Policy terminates; or
- (e) the date Your employment with the Policyholder or subscribing Employer unit ends,

whichever first occurs. We will require proof on an annual basis that You remain Disabled during said period.

WP]

## **[WAIVER OF PREMIUM DURING A STRIKE OR LOCKOUT**

If You are not on Active Employment and You:

- (a) participate in a lawful strike authorized by Your union; or
- (b) are locked out as the result of a labor dispute between Your union and Your Employer; and

the strike or lockout has lasted 30 consecutive days, We will waive Your premium payments beginning on the next premium due date if the strike or lockout continues.

Your eligibility will be maintained and premium will be waived if:

- (a) You were on Active Employment and covered under the Policy before the strike or lockout began; and
- (b) We receive written proof from You or Your labor union that the strike or lockout meets the conditions stated above.

If You become Disabled while on strike or lockout and Your Disability continues beyond the date of Your scheduled return to Active Employment, benefits will become payable after satisfaction of the Elimination Period provided premiums have been waived under this provision for the duration of the strike or lockout and You resume premium payments upon Your scheduled return to Active Employment. The Elimination Period will begin with the date of Your scheduled return to Active Employment following the strike or lockout period.

You must notify Us when:

- (a) the strike or lockout is resolved;
- (b) You have returned to Active Employment;
- (c) You are offered the opportunity to return to work for Your Employer; or
- (d) Your employment is terminated.

After the strike or lockout has ended, You may continue Your insurance by resuming payments on the first premium due date on or after Your return to Active Employment. If premium payment is not resumed, Your insurance will terminate on the last day of the period for which premium has been paid.

If the strike or lockout continues beyond [6 months, 12 months], Waiver of Premium will end and Your coverage will terminate.

**RE-ENROLLMENT AFTER STRIKE OR LOCKOUT:** If You are not on Active Employment due to a strike or lockout and Your insurance terminates, You may re-enroll for coverage not to exceed the amount previously held without furnishing evidence of good health provided You submit a new enrollment application within 30 days of Your return to Active Employment.

WPSJ

**SECTION 4**  
**[LIMITATIONS AND EXCLUSIONS]**  
**[EXCLUSIONS]**

**[MENTAL ILLNESS LIMITED BENEFIT**

If You are Disabled due to a Mental Illness, Disability Payments will be provided for the Maximum Mental Illness Period shown in the Schedule if:

- (a) You are under the Regular and Appropriate Care of a Physician; and
- (b) You receive medical treatment (mental or medical examination alone will not be considered treatment) from either:
  - (1) a registered specialist in psychiatry;
  - (2) a Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
  - (3) a Physician, if in Our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

**MENTAL ILLNESS** means Disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as:

- (a) schizophrenia;
- (b) depression;
- (c) manic depressive or bipolar illness;
- (d) anxiety;
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke;
- (b) trauma;
- (c) viral infection;
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

MI]

**[SPECIAL CONDITIONS LIMITED BENEFIT**

If You are Disabled due to a Special Condition and You are under the Regular and Appropriate Care of a Physician, Disability Payments will be provided for the Special Conditions Period shown in the Schedule.

Special Conditions means:

- (a) Chronic Fatigue Syndrome.
- (b) Fibromyalgia.
- (c) Environmental allergic illness, including, but not limited to sick building syndrome and multiple chemical sensitivity.
- (d) Self-Reported Symptoms. Self-Reported Symptoms means the manifestations of Your condition that You tell Your Physician that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of Self-Reported Symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- [(e) Any disease, disorder, accident or injury of the neck or back not resulting in hemiplegia, paraplegia, or quadriplegia;]

SP-CON]

### **[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT**

If You are Disabled due to alcoholism or drug addiction, a limited benefit of up to [15 days, 30 days, 90 days, 1 year] for each Disability will be paid. In no event will benefits be paid beyond the Maximum Disability Period shown in the Schedule. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Injury or Sickness, it will be covered the same as any other illness.

ALC]

### **[PRE-EXISTING CONDITION LIMITATION**

No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before You have been continuously covered under the Policy for 12 months.

This provision will not apply if You have:

- (a) gone treatment-free;
- (b) incurred no expense
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for [3, 6, 12] consecutive months after the Effective Date of coverage for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after You have been continuously covered under the Policy for 12 months.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by Us.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE1]

### **[PRE-EXISTING CONDITION LIMITATION**

A limited benefit up to 1 month's Disability Benefit will be payable for Disability caused by or resulting from a Pre-Existing Condition. This provision will not apply if You have:

- (a) gone treatment-free;
- (b) incurred no expense
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for [3, 6, 12] consecutive months after the Effective Date of coverage for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after You have been continuously covered under the Policy for 12 months.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by Us.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE2]

### **[PRE-EXISTING CONDITION LIMITATION**

If Disability is caused by or resulting from a Pre-Existing Condition and begins before You have been continuously covered under the Policy for 12 months, no Disability Benefit will be payable.

[Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by Us.]

[No consideration will be given to prior group disability income coverage in determining the effect of Pre-Existing Conditions on benefits payable.]

PE3]

**[PRE-EXISTING CONDITION** means a disease, Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the [90-day, 3-month, 6-month, 12-month, 24-month] period immediately before the Effective Date of Your coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

PEDEF]

### **[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS**

For all employees who were insured by their current Employer's prior group disability carrier on the day preceding the Employer's Effective Date of coverage under this Policy and who became insured with American Public Life Insurance Company on the Employer's Effective Date of coverage under this Policy, coverage for Pre-Existing Conditions will be administered as follows:

If You were not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group disability carrier, there would be no Pre-Existing Condition Limitation applied under the American Public Life plan. If You were not eligible for benefits under the prior group disability carrier's plan because of a Pre-Existing Condition Limitation, You would not be eligible for benefits under the American Public Life plan until such time as You had satisfied the Pre-Existing Condition limitation described in the Policy. Credit will be given for any portion of time satisfied with Your current Employer's prior group disability carrier provided You replaced that coverage with American Public Life's insurance on the Effective Date. This provision applies only up to the amount of coverage You held with the prior group disability carrier on the day preceding American Public Life's Effective Date. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group disability carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CC]

## **[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS**

For all employees who were insured by their current Employer's prior group disability carrier on the day preceding the Employer's Effective Date of coverage under this Policy and who became insured with American Public Life Insurance Company on the Employer's Effective Date of coverage under this Policy, coverage for Pre-Existing Conditions will be administered as follows:

If You were not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group disability carrier, there would be no Pre-Existing Condition Limitation applied for a Disability Benefit up to [\$1,500, \$2,000, \$3,000, \$4,000, \$5,000] under the American Public Life plan. If You were not eligible for benefits under the prior group disability carrier's plan because of a Pre-Existing Condition Limitation, You would not be eligible for benefits under the American Public Life plan until such time as You had satisfied the Pre-Existing Condition limitation described in the Policy. Credit will be given for any portion of time satisfied with Your current Employer's prior group disability carrier provided You replaced that coverage with American Public Life's insurance on the Effective Date. This provision applies only:

- (a) for a Disability Benefit up to [\$1,500, \$2,000, \$3,000, \$4,000, \$5,000] under the American Public Life plan; and
- (b) up to the Maximum Disability Period You held with the prior group disability carrier on the day preceding American Public Life's Effective Date.

Any Disability Benefit exceeding this amount will be subject to the Pre-Existing Condition Limitation. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group disability carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CC1]

## **EXCLUSIONS**

The Policy does not cover any loss, fatal or non-fatal, which results from any of the following:

- (a) Intentionally self-inflicted Injury while sane or insane.
- (b) An act of war, declared or undeclared.
- (c) Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- (d) Committing a felony.
- (e) Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which You are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
- [(f) [Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which You are entitled to Workers' Compensation\*.

\*The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements that occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which You are entitled to Workers' Compensation benefits.]

EXC

## **SECTION 5 TERMINATION OF INSURANCE**

Your insurance coverage will end on the earliest of these dates:

- (a) the date You do not meet the Eligibility requirements as defined in Section 2;
- (b) the date You retire;
- (c) the date You cease to be on Active Employment as defined in Section 1, except as provided for under the Leave of Absence provision in this Section;
- (d) the end of the last period for which premium has been paid;
- (e) the date the Policy is discontinued; or
- (f) the date Your employment terminates.

If:

- (a) Your coverage ends as a result of Your termination of Active Employment;
- (b) such termination is caused by an Injury or Sickness for which Disability Benefits would be payable; and
- (c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no effect on Disability Payments that began before such termination.

We may end Your coverage if You make a fraudulent claim.

We, or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

### **LEAVE OF ABSENCE**

Your coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by Your Employer.

TOI

### **[CONVERSION OPTION**

If You end Your employment You may be eligible to continue coverage under Our group conversion policy. You are eligible to apply for conversion coverage if:

- (a) You have been continuously covered under the Policy for at least 12 consecutive months prior to the date Your employment terminated;
- (b) You are not Disabled;
- (c) You are not covered under any other group disability income plan;
- (d) You are employed and working at least 25 hours per week, excluding self-employment, on the date Your conversion coverage becomes effective;
- (e) You are not on a leave of absence;
- (f) Your employment was not terminated due to retirement; and
- (g) You are less than age 70.

You must apply for conversion coverage and pay the first premium within 30 days after the date Your employment ends. Coverage will be issued without evidence of insurability. To receive a group conversion application please contact Our office.

Upon receipt of Your application and premium payment, a Certificate will be issued to You. The conversion policy may not provide the same coverage You had under Your Employer's plan. Your Disability Benefit under the conversion policy will not be greater than the Disability Benefit under this plan when your coverage ended.

CONV]

**SECTION 6**  
**PREMIUM CALCULATION AND PAYMENT**

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) Our Home Office; or
- (b) an authorized entity of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

PREM

**SECTION 7  
GENERAL PROVISIONS**

**ENTIRE CONTRACT-CHANGES:** The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Disability (as defined in the Policy) that starts after such 2-year period.

**GRACE PERIOD:** A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

**NOTICE OF CLAIM:** Written Notice of Claim must be given to Us at 2305 Lakeland Drive, Flowood, Mississippi 39232, or to Our agent. Such Notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give Notice within that time, the claim may not be denied or reduced due to the delay.

**PROOF OF LOSS:** Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, must show:

- (a) that You are under the Regular and Appropriate Care of a Physician;
- (b) the date Your Disability began;
- (c) the cause of Your Disability;
- (d) the appropriate documentation of Your Monthly Compensation;
- (e) the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation; and
- (f) the name and address of any Hospital or institution where You received treatment, including all attending Physicians.

**CLAIM FORMS:** Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

**TIME OF PAYMENT OF CLAIMS:** All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written Proof. Benefits for any other covered loss will be paid as soon as We receive written proof of such Proof of Loss.

**PAYMENT OF BENEFITS:** All benefits will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or to You and You are not competent to give a valid release, We may pay up to \$1,000 of such benefit to one of Your relatives who are deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

**PHYSICAL EXAMINATION:** While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by an authorized Company representative to determine the extent of any Sickness or Injury for which You have made a claim. This right may be used as often as reasonably required.

**LEGAL ACTION:** No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

**CERTIFICATES:** An Individual Certificate will be issued to You. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

**MISSTATEMENT OF FACTS:** If relevant facts regarding You are not accurate:

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

**CONFORMITY WITH STATE LAWS:** A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

**CLAIM OVERPAYMENT:** We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You may be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

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

- (a) recover such overpayments from:
  - (1) You;
  - (2) any other person to or for whom payment was made;
  - (3) Your estate;
  - (4) Your beneficiary;
  - (5) any other organization; and
  - (6) any other insurance company;
- (b) reduce or offset against any future benefits payable to You, Your Estate, Your Survivors, or Your Beneficiary, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- (c) refer Your unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

GENPROV

 **American Public Life Insurance Company**

A member of the American Fidelity Group

Contract Number: \_\_\_\_\_

2305 Lakeland Drive • Flowood, MS • 39232 • Phone: (800) 256-8606 • Fax: (877) 807-0911

Application for **Group Disability Income Insurance** is hereby made to American Public Life Insurance Company based on the following:

- 1. Full Legal Name of Policyholder: \_\_\_\_\_
- 2. Mailing Address: \_\_\_\_\_
- 3. Physical Address (if different): \_\_\_\_\_
- 4. Group Type:  Association  Corporation  Sole Proprietorship or Partnership  Education  Other
- 5. Nature of Organization: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_
- 6. Designation of Class or Classes Eligible for Coverage (attach an additional page if necessary): \_\_\_\_\_

- 7. Current employees are eligible:  Immediately  After \_\_\_\_\_ days employment  As determined by each firm
- 8. New employees are eligible after \_\_\_\_\_ days employment.
- 9. Minimum Standards: Before this Policy or the insurance of additional persons or a change in class takes effect, the following applicable minimum standards must be met. Where the Policyholder is a/an:  Employer  Trust  Association, the participation requirements are as follows: \_\_\_\_\_

If these standards are not met, it is agreed that the Company may:

- (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect; or
- (2) terminate the Policy or Subscribing Unit.

To issue coverage and maintain eligibility: \_\_\_\_\_

- 10. Initial Premium rate is as follows: \_\_\_\_\_  
The premium is due on the \_\_\_\_\_ of each month.
- 11. Effective Date: \_\_\_\_\_ Original Policy Effective Date: \_\_\_\_\_ Policy Amended Effective: \_\_\_\_\_  
If this application is approved by the Company, it is desired that the Policy takes effect at 12:01 AM at the place where the Policy is delivered. It is agreed that the coverage of an eligible person will not take effect until the first premium has been paid for or by such person.
- 12. The Policyholder declares that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered.
- 13. I hereby request American Public Life Insurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied. I agree to make payroll deductions for the Employee portion of any premium.
- 14.  Non-ERISA Group  
 ERISA Acknowledgment: The Employer named below acknowledges that the Employee Retirement Income Security Act of 1974 (ERISA), as amended or other laws, if applicable, may require that the Employer be responsible for certain duties or obligations with respect to the Employer or Employer's Employees and dependents under any certificate under such group policy or policies.

Dated at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Authorized Signature: \_\_\_\_\_ Official Position: \_\_\_\_\_

Agent: \_\_\_\_\_ Agent Number: \_\_\_\_\_

**FRAUD WARNING:** Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)



A member of the American Fidelity Group.

2305 Lakeland Drive Flowood, MS 39232
Phone: (800) 256-8606 FAX: (877) 807-0911

FOR AGENT USE ONLY:

Requested Effective Date: \_\_\_\_\_

Bill Location: \_\_\_\_\_

GROUP DISABILITY INCOME APPLICATION

1. PROPOSED INSURED INFORMATION
Last Name First Name Full Middle Name Suffix
Age Date of Birth Sex Soc Sec Number Date of Employment
Residence Address: Number & Street (Not a P.O. Box) City State Zip
Home Phone # Work Phone # Country of Citizenship
Mailing Address (if different than Residence) City State Zip
Employer Name Salary: \$ Occupation
Are you currently able to perform the duties of your occupation? Yes No

Applicant's E-mail Address

2. BENEFITS APPLIED FOR

Table with 8 columns: Product, New, Change, Benefit Amount, Employee, Employer, Frequency, Total. Rows include [STD] and [Rider] with checkboxes and dollar amounts.

3. BENEFICIARY

First Name Middle Name Last Name Relationship to Insured Country of Citizenship

4. ELECTION I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my premiums, if any, from my pay.

5. ACKNOWLEDGMENT I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.
"Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.

BROCHURE(S) # HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Applicant Initials):

6. FRAUD NOTICE Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

APPLICANT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

AGENT SIGNATURE (where required by law) \_\_\_\_\_ Agent # \_\_\_\_\_

**AMERICAN PUBLIC LIFE INSURANCE COMPANY**

2305 Lakeland Drive, Flowood, MS 39232

**GROUP DISABILITY INCOME APPLICATION**

**PROPOSED INSURED'S NAME** \_\_\_\_\_

**HEALTH HISTORY**

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7. Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes  No

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8. Within the **past 12 months**, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes  No

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9. Are you currently pregnant?

Yes  No

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10. I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

SERFF Tracking Number: AFDL-127094195 State: Arkansas  
 Filing Company: American Public Life Insurance Company State Tracking Number: 48323  
 Company Tracking Number: GDIS11APL  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
 Product Name: GDIS11APL Group Disability Income Policy  
 Project Name/Number: APL Group STD Policy /GDIS11APL/C

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> GDIS11APL_AR_Compliance_Certification.pdf	Approved-Closed	03/28/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachments:</b> A1269.pdf AGM107.pdf	Approved-Closed	03/28/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of Authorization <b>Comments:</b> <b>Attachment:</b> APL_Authorization11.pdf	Approved-Closed	03/28/2011



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

**COMPLIANCE CERTIFICATION**

**ARKANSAS**

This is to certify that the attached forms comply with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA-23-79-138

  
\_\_\_\_\_  
Signature

John Lanier, Vice President  
\_\_\_\_\_  
Name and Title

3/23/2011  
\_\_\_\_\_  
Date



A member of the American Fidelity Group.

2305 Lakeland Drive Flowood, MS 39232
Phone: (800) 256-8606 FAX: (877) 807-0911

FOR AGENT USE ONLY:

Requested Effective Date: \_\_\_\_\_

Bill Location: \_\_\_\_\_

GROUP DISABILITY INCOME APPLICATION

1. PROPOSED INSURED INFORMATION
Last Name First Name Full Middle Name Suffix
Age Date of Birth Sex Soc Sec Number Date of Employment
Residence Address: Number & Street (Not a P.O. Box) City State Zip
Home Phone # Work Phone # Country of Citizenship
Mailing Address (if different than Residence) City State Zip
Employer Name Salary: \$ Occupation
Are you currently able to perform the duties of your occupation? Yes No

Applicant's E-mail Address

2. BENEFITS APPLIED FOR

Table with columns: Product, New, Change, Benefit Amount, Employee, Employer, Frequency, Total. Includes rows for [STD] and [Rider] and a TOTAL \$ row.

3. BENEFICIARY

First Name Middle Name Last Name Relationship to Insured Country of Citizenship

4. ELECTION I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my premiums, if any, from my pay.

5. ACKNOWLEDGMENT I understand and agree that:
• The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
• If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.
• "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.
• BROCHURE(S) # HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Applicant Initials):

6. FRAUD NOTICE Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

APPLICANT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

AGENT SIGNATURE (where required by law) \_\_\_\_\_ Agent # \_\_\_\_\_

**AMERICAN PUBLIC LIFE INSURANCE COMPANY**

2305 Lakeland Drive, Flowood, MS 39232

**GROUP DISABILITY INCOME APPLICATION**

**PROPOSED INSURED'S NAME** \_\_\_\_\_

**HEALTH HISTORY**

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7. Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes  No

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8. Within the **past 12 months**, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes  No

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9. Are you currently pregnant?

Yes  No

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10. I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

 **American Public Life Insurance Company**

A member of the American Fidelity Group

Contract Number: \_\_\_\_\_

2305 Lakeland Drive • Flowood, MS • 39232 • Phone: (800) 256-8606 • Fax: (877) 807-0911

Application for **Group Disability Income Insurance** is hereby made to American Public Life Insurance Company based on the following:

- 1. Full Legal Name of Policyholder: \_\_\_\_\_
- 2. Mailing Address: \_\_\_\_\_
- 3. Physical Address (if different): \_\_\_\_\_
- 4. Group Type:  Association  Corporation  Sole Proprietorship or Partnership  Education  Other
- 5. Nature of Organization: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_
- 6. Designation of Class or Classes Eligible for Coverage (attach an additional page if necessary): \_\_\_\_\_

- 7. Current employees are eligible:  Immediately  After \_\_\_\_\_ days employment  As determined by each firm
- 8. New employees are eligible after \_\_\_\_\_ days employment.
- 9. Minimum Standards: Before this Policy or the insurance of additional persons or a change in class takes effect, the following applicable minimum standards must be met. Where the Policyholder is a/an:  Employer  Trust  Association, the participation requirements are as follows: \_\_\_\_\_

If these standards are not met, it is agreed that the Company may:

- (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect; or
- (2) terminate the Policy or Subscribing Unit.

To issue coverage and maintain eligibility:

- 10. Initial Premium rate is as follows: \_\_\_\_\_  
The premium is due on the \_\_\_\_\_ of each month.
- 11. Effective Date: \_\_\_\_\_ Original Policy Effective Date: \_\_\_\_\_ Policy Amended Effective: \_\_\_\_\_  
If this application is approved by the Company, it is desired that the Policy takes effect at 12:01 AM at the place where the Policy is delivered. It is agreed that the coverage of an eligible person will not take effect until the first premium has been paid for or by such person.
- 12. The Policyholder declares that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered.
- 13. I hereby request American Public Life Insurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied. I agree to make payroll deductions for the Employee portion of any premium.
- 14.  Non-ERISA Group  
 ERISA Acknowledgment: The Employer named below acknowledges that the Employee Retirement Income Security Act of 1974 (ERISA), as amended or other laws, if applicable, may require that the Employer be responsible for certain duties or obligations with respect to the Employer or Employer's Employees and dependents under any certificate under such group policy or policies.

Dated at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Authorized Signature: \_\_\_\_\_ Official Position: \_\_\_\_\_

Agent: \_\_\_\_\_ Agent Number: \_\_\_\_\_

**FRAUD WARNING:** Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)



# American Public Life Insurance Company

**A member of the American Fidelity Group.**

January 2, 2011

NAIC Number: 60801  
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73125, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of American Public Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Alex M. Bagby, ASA, MAAA  
Vice President & Chief Risk Officer