

SERFF Tracking Number: GRJR-127058514 State: Arkansas
Filing Company: The Cincinnati Life Insurance Company State Tracking Number: 48155
Company Tracking Number: CLI85721110
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Form CLI-8572 (11/10) When the decision is this important
Project Name/Number: Point of Sale Advertising/Point of Sale Advertising

Filing at a Glance

Company: The Cincinnati Life Insurance Company

Product Name: Form CLI-8572 (11/10) When the decision is this important SERFF Tr Num: GRJR-127058514 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-Closed State Tr Num: 48155

Sub-TOI: H21.000 Health - Other

Co Tr Num: CLI85721110

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Jennifer Henley, Deborah Naegele, Karen Eichler, Felicia

Disposition Date: 03/04/2011

McCalley

Date Submitted: 03/03/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Point of Sale Advertising

Status of Filing in Domicile: Not Filed

Project Number: Point of Sale Advertising

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 03/04/2011

State Status Changed: 03/04/2011

Deemer Date:

Created By: Felicia McCalley

Submitted By: Felicia McCalley

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

FEIN: 31-1213778

NAIC: 76236

Subject: The Cincinnati Life Insurance Company

SERFF Tracking Number: GRJR-127058514 State: Arkansas
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Point of Sale Advertising
Form CLI-8572 (11/10), When the decision is this important

Replaces: Form CLI-8572 (1/09), previously approved by your department on May 7, 2009.

For Use With: Form CLI-507-AR (3/01) Worksite DI Policy, previously approved by your department on June 11, 2001.

Dear Madame or Sir:

The above-captioned form is being submitted for your review and approval. This form is new and will replace the above mentioned form.

The form we are filing may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document but we assure that its content will not change.

I would greatly appreciate your approval at your earliest convenience. Thank you for your usual courtesy and cooperation.

Company and Contact

Filing Contact Information

Felicia McCalley, Analyst Trainee felicia_mccalley@cinfin.com
P.O. Box 145496 513-870-2279 [Phone]
Cincinnati, OH 45250-5496

Filing Company Information

The Cincinnati Life Insurance Company CoCode: 76236 State of Domicile: Ohio
6200 S. Gilmore Road Group Code: 244 Company Type:
Fairfield, OH 45014 Group Name: State ID Number:
(513) 870-2000 ext. 4386[Phone] FEIN Number: 31-1213778

Filing Fees

SERFF Tracking Number: GRJR-127058514 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: 1 Form x \$50.00 each
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Cincinnati Life Insurance Company	\$50.00	03/03/2011	45236560

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/04/2011	03/04/2011

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Disposition

Disposition Date: 03/04/2011

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review:

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	When the decision is this important	Approved-Closed	Yes

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Form Schedule

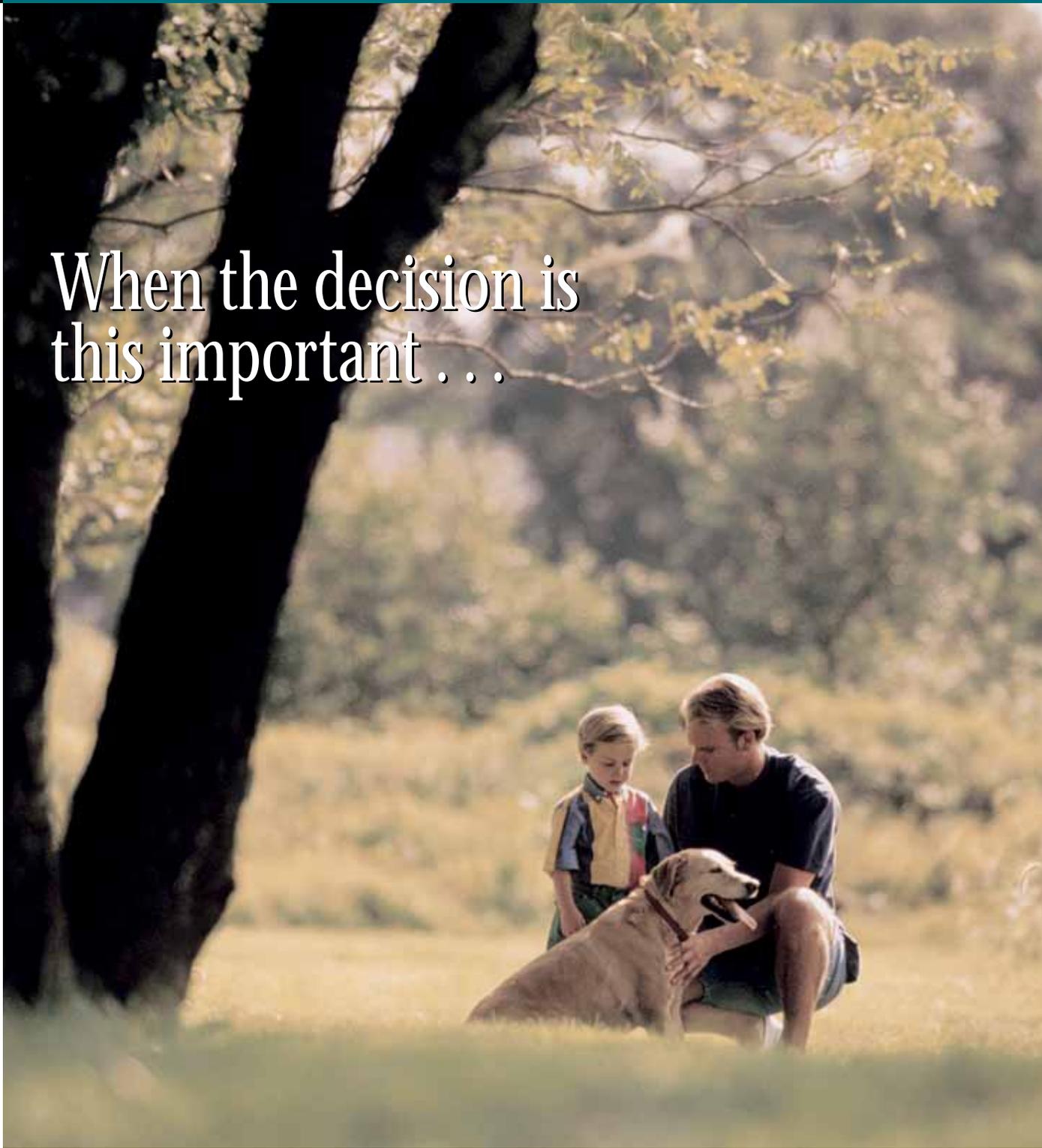
Lead Form Number: Form CLI-8572 (11/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/04/2011	Form CLI-8572 (11/10)	Advertising	When the decision is this important	Revised	Replaced Form #: Form CLI-8572 (1/09) Previous Filing #: N/A Paper filing		Form CLI-8572 (11-10).pdf



Protecting Your Lifestyle

When the decision is
this important . . .



LifeHorizons Disability Income Insurance
Policy Form CLI-507

**THE
CINCINNATI LIFE INSURANCE COMPANY**

Protect Your Future by Knowing the Facts

How would you respond if you were asked, “What is your most valuable asset?” Would it be your home? Your car? Jewelry? Or possibly some other prized possession?

In most cases, our most valuable asset is not a material one. It is our ability to work and earn a living. Many people overlook this asset when determining their insurance needs. Disability income insurance provides a source of replacement income if you are unable to work due to an illness or accident.

LifeHorizons Disability Income* (DI) insurance can help you plan for the unexpected loss of income due to a disabling sickness or injury. Studies show that 80 percent of U.S. workers would exhaust their savings within two months if they lost their ability to earn an income.¹ With LifeHorizons DI, you and your loved ones can still maintain a comfortable lifestyle until you return to work.

Consider these important facts:

- Three out of every 10 workers between the ages of 25 and 65 will experience an accident or sickness that will keep them away from work for three months or longer.²
- A 35-year-old is six times more likely to suffer a disability than to die before reaching age 65.³
- Nearly 60 percent of all injuries happen off the job.³

LifeHorizons DI can answer the following difficult questions:

- How long could you live off of your **savings**?
- Could you live on **borrowed funds** during a particularly severe disability?
- Would **liquidating your assets** provide enough money to see you through a long disability?
- Is it realistic to assume your **spouse's income** would suffice?
- Would **workers' compensation** or **Social Security** benefits see you through truly difficult times?

You should consider disability income insurance if:

- you are self-employed or a small corporate owner
- you work for a company with insufficient short- and long-term disability benefits
- your group medical package terminates when a disability strikes
- your disability benefits are limited to workers' compensation insurance only
- you are the owner/principal of a business and are excluded from workers' compensation
- your family is a single-income family
- you are a single individual with no alternative source of income

* Available in most states.

¹ Commissioners Disability Table

² Commissioners Group Disability Income Table

³ American Council of Life Insurers



Things to Consider When Buying Disability Income Insurance

Many factors determine the cost of an individual disability income policy.

Age

Younger individuals pay less per year for a policy than those who are older since they are less likely to become disabled.

Type of Job

Since the policy provides income if you become unable to work due to an illness or injury, premiums are higher for a policy that covers an individual working in a high-risk occupation compared to a low-risk occupation.

Benefit Amount

The greater the amount of income that the policy replaces, the more valuable the policy. A policy that replaces 60 percent of your salary is more valuable than one that replaces only 40 percent of your salary.

Benefit Period

This is the amount of time you will receive benefits from your policy. The longer the benefit period, the more coverage you have.

Current Health Status

Your health status determines whether you are eligible for coverage and may affect the cost of your policy. A policy may also exclude from coverage any health condition that existed prior to the policy being issued.

Definition of Disability

A policy that provides benefits if you are unable to perform the duties of your own occupation is more beneficial than a policy that only provides benefits if you are unable to perform the duties of any job for which you are reasonably qualified.

Elimination Period

This is the waiting period before benefit payments begin and is often compared to the deductible on an automobile or major medical expense policy. The elimination period usually ranges from 30 days to six months or more after the onset of the disability. When choosing an elimination period, you should consider how long you can maintain an acceptable standard of living through sick-pay benefits, personal savings or investments without an earned income. The longer the elimination period, the lower the premium.

Calculate Your Need

Monthly Income Available

Income from current group DI coverage	\$ _____
Income from current individual DI coverage	_____
Income from spouse or family members	_____
Monthly investment income	_____
Total Monthly Income Available	\$ _____

Monthly Expenses

Mortgage (including property taxes) or rent	\$ _____
Homeowner's or renter's insurance	_____
Car payment and insurance	_____
Utilities	_____
Food and clothing	_____
Bank loan or credit card payments	_____
Medical expenses	_____
Health insurance premiums	_____
Life insurance premiums	_____
Savings/investment contributions	_____
Home maintenance costs	_____
Other (education, etc.)	_____
Total Monthly Expenses	\$ _____

Subtract your Total Monthly Expenses from your Total Monthly Income Available. The deficit amount is the amount of disability income insurance you should consider.

Total DI Coverage Needed \$ _____

About

Cincinnati Life

Cincinnati Life, a wholly owned subsidiary of The Cincinnati Insurance Company, has grown and prospered by successfully serving policyholders for more than 20 years. Your policy comes from a company that has a high financial strength rating from A.M. Best Co., an independent provider of insurance ratings since 1899. Our A.M. Best rating places our company among the top life insurers. Please view www.cinfin.com for our latest financial strength ratings.

For more information, please contact your local independent agent recommending coverage:

This is not a policy. For a complete statement of the coverages and exclusions, please see the policy contract. All applicants are subject to underwriting approval. Products available in most states.



The Cincinnati Insurance Companies refers to an insurer group that includes The Cincinnati Life Insurance Company.

THE
CINCINNATI LIFE INSURANCE COMPANY

6200 S. GILMORE ROAD, FAIRFIELD, OH 45014-5141

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification	Approved-Closed	03/04/2011
Bypass Reason: N/A - Advertising filing		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/04/2011
Comments: Form CLI-8572 (11/10) will be used with the attached form		
Attachment: CLI-507-AR 03-01.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	03/04/2011
Bypass Reason: N/A - Advertising filing		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	03/04/2011
Bypass Reason: N/A - Advertising filing		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	03/04/2011
Bypass Reason: N/A - Advertising filing		
Comments:		

**THE
CINCINNATI LIFE INSURANCE COMPANY**

P.O. BOX 145496, CINCINNATI, OHIO 45250-5496
(513) 870-2000

30 DAY RIGHT TO EXAMINE POLICY

We want you to be satisfied with your Insurance. Please read this Policy carefully. You may return this Policy to us or to any of our agents within 30 days after it is received by you. If you return this Policy, it will be void from the start and any premiums paid will be refunded to you.

The Cincinnati Life Insurance Company agrees to pay the insurance benefits provided by this Policy upon receipt of satisfactory written proof of loss with respect to the Insured, in accordance with the provisions of this Policy.

This Policy takes effect on the Effective Date of your Insurance shown in the Schedule of Insurance. All periods indicated in the Policy begin and end at 12:01 A.M. Standard Time at the home address of the Insured. The consideration for this Policy is your application for Insurance and the payment of the required premiums as they become due.

THIS POLICY HAS BEEN DELIVERED IN the Issue State shown in the Schedule of Insurance and is governed by the laws of that state and to the extent applicable by the federal Employee Retirement Income Security Act of 1974, as amended (ERISA).

PLEASE READ THIS POLICY CAREFULLY: This Policy describes the benefits, provisions, exclusions, limitations, and restrictions of the Insurance that apply to you. This Policy has a Table of Contents following the Schedule of Insurance to help you find specific provisions. The terms "you" and "your" refer to the Insured named in the Schedule of Insurance. If the Insured is not the Owner, then "you" and "your" mean the Owner when referring to contract rights, payments, and notices. The Owner is named in the Application. The terms "we," "us," and "our" refer to The Cincinnati Life Insurance Company. All other defined terms are printed with an initial capital letter.

RENEWABILITY AND OUR RIGHT TO CHANGE PREMIUMS

GUARANTEED RENEWABLE THROUGH AGE 64: You may renew this Policy at the end of each term until you are age 65. We have the right to change the premium rates for all insureds in the same Rate Class on any premium due date.

CONDITIONALLY RENEWABLE AT AGES 65 THROUGH 69: You may renew this Policy while you are regularly scheduled to work at least 30 hours each week. We have the right to change the premium rates for all insureds in the same Rate Class on any premium due date.

INSURANCE ENDS ON THE DATE YOU BECOME AGE 70.

The Cincinnati Life Insurance Company

Kenneth W. Fisher

Secretary

David Popplwell

President

DISABILITY INSURANCE POLICY

Nonparticipating

INSURED: JOHN DOE

POLICY NUMBER: 12345678

Form CLI-507-AR (3/01)



THE CINCINNATI LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

INSURED: JOHN DOE

AGE: 35

RATE CLASS:
 GENDER: [MALE][FEMALE][UNISEX]
 OCCUPATIONAL CLASS: [A1]
 PREMIUM CLASS: [SUBSTANDARD][STANDARD][TOBACCO][NON-TOBACCO]

POLICY NUMBER: 12345678

ISSUE STATE: OHIO

EFFECTIVE DATE: JULY 1, 2001

MAXIMUM MONTHLY
 DISABILITY BENEFIT: [\$500 - \$12,000]

ELIMINATION PERIOD: [30][60][90][180][365] DAYS

OWN OCCUPATION PERIOD: [24][60] MONTHS

MAXIMUM BENEFIT PERIOD: (1) [TO AGE 65]

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
64 OR YOUNGER	TO AGE 65 OR 24 MONTHS (WHICHEVER IS LONGER)
65 THROUGH 69	12 MONTHS
70 OR OLDER	NONE

[FIVE YEARS]

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
59 OR YOUNGER	TO AGE 65 OR 60 MONTHS (WHICHEVER IS SHORTER)
60 THROUGH 64	TO AGE 65 OR 24 MONTHS (WHICHEVER IS LONGER)
65 THROUGH 69	12 MONTHS
70 OR OLDER	NONE

[TWO YEARS]

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
64 OR YOUNGER	24 MONTHS
65 THROUGH 69	12 MONTHS
70 OR OLDER	NONE

[ONE YEAR]

<u>AGE WHEN DISABILITY BEGINS</u>	<u>MAXIMUM BENEFIT PERIOD</u>
69 OR YOUNGER	12 MONTHS
70 OR OLDER	NONE

- (1) THE MAXIMUM BENEFIT PERIOD IS DETERMINED BY YOUR AGE ON THE DATE YOU BECOME DISABLED.

SPECIMEN

THE CINCINNATI LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

PREMIUMS

PREMIUM PAYMENT PERIOD: TO AGE 70

INITIAL MODAL PREMIUM: [*\$XXXX]
(INCLUDES RIDERS)

INITIAL ANNUAL PREMIUM: (1) [*\$XXXX]
(WITHOUT RIDERS)

PREMIUM PAYMENT MODE: (2) [MONTHLY][QUARTERLY][SEMIANNUALLY][ANNUALLY]

[*INCLUDES EXTRA CHARGE FOR SUBSTANDARD RISK.]

- (1) CHANGES IN PREMIUM BASED ON CHANGES IN YOUR AGE ON AND AFTER YOUR 65TH BIRTHDAY WILL BECOME EFFECTIVE ON THE ANNIVERSARY OF THE EFFECTIVE DATE OF YOUR INSURANCE COINCIDING WITH OR NEXT FOLLOWING THE DATE OF YOUR BIRTHDAY. INSURANCE ENDS ON THE DATE YOU BECOME AGE 70.
- (2) IF PREMIUMS ARE PAYABLE OTHER THAN ANNUALLY, THE FOLLOWING MODE FACTOR WILL BE USED TO DETERMINE THE AMOUNT OF EACH MODAL PREMIUM:

<u>PREMIUM MODE</u>	<u>MODE FACTOR</u>
SEMIANNUAL	.5150 OF ANNUAL PREMIUM
QUARTERLY	.2650 OF ANNUAL PREMIUM
MONTHLY	.0900 OF ANNUAL PREMIUM
BANK-O-MATIC	.0880 OF ANNUAL PREMIUM
LIST BILL	.0880 OF ANNUAL PREMIUM

IF YOU ELECT TO PAY PREMIUMS OTHER THAN ANNUALLY, THE TOTAL AMOUNT OF THE PREMIUMS YOU PAY EACH YEAR WILL BE GREATER THAN THE INITIAL ANNUAL PREMIUM BECAUSE OF: 1) THE LOSS OF INTEREST WHICH THE COMPANY WOULD EARN IF THE INITIAL ANNUAL PREMIUM WERE PAID IN ONE LUMP SUM AT THE START OF THE YEAR; AND 2) THE ADDITIONAL COST OF COLLECTING THE PERIODIC PREMIUMS. THE MODE FACTOR EXPRESSED AS A PERCENTAGE OF THE INITIAL ANNUAL PREMIUM, IS 3% FOR SEMIANNUAL, 6% FOR QUARTERLY, 8% FOR MONTHLY, AND 5.6% FOR BANK-O-MATIC AND LIST BILL.

THE CINCINNATI LIFE INSURANCE COMPANY

SCHEDULE OF INSURANCE

OPTIONAL COVERAGE RIDERS

BENEFIT	ANNUAL PREMIUM	PREMIUM EXPIRY
[ENHANCED PARTIAL DISABILITY BENEFIT RIDER]	[\$XXXXX]	AT AGE 65 (1)
[3% COST OF LIVING ADJUSTMENT RIDER]	[\$XXXXX]	AT AGE 65 (1)
[GUARANTEED INSURABILITY RIDER]	[\$XXXX]	AT AGE 55 (1)
[SURVIVOR RETURN OF PREMIUM RIDER]	[\$XXXXX]	AT AGE 70
[SPOUSE CATASTROPHIC IMPAIRMENT BENEFIT RIDER]	[\$XXXXX]	AT AGE 65 (1)
[NONINTEGRATION RIDER]	[\$XXXXX]	AT AGE 65 (1)
[BUSINESS OVERHEAD EXPENSE BENEFIT RIDER]	[\$XXXXX]	AT AGE 65 (1)

[*INCLUDES EXTRA CHARGE FOR SUBSTANDARD RISK.]

(1) THE PREMIUM IS PAYABLE UNTIL THE ANNIVERSARY OF THE EFFECTIVE DATE OF YOUR INSURANCE COINCIDING WITH OR NEXT FOLLOWING ATTAINMENT OF THE AGE SHOWN.

BUSINESS OVERHEAD EXPENSE BENEFIT:

MAXIMUM MONTHLY BENEFIT:	[\$500- \$15,000]
ELIMINATION PERIOD:	30 DAYS
MAXIMUM BENEFIT PERIOD:	12 MONTHS

GUARANTEED INSURABILITY RIDER:

MAXIMUM AMOUNT OF INCREASES:	[\$5,000]
DATE OF FIRST AVAILABLE INCREASE:	[SEPTEMBER 1, 2002]

SPECIMEN

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Part 1. MONTHLY DISABILITY BENEFITS

We will pay Monthly Disability Benefits to you if you provide us with satisfactory written proof that you have become Disabled prior to age 70 and while your Insurance is in force, subject to all the terms and conditions of this Insurance. You must provide us with satisfactory written proof of loss with respect to your claim for Monthly Disability Benefits. See "How To Claim Benefits."

After you have been Disabled throughout the Elimination Period shown in the Schedule of Insurance, we will pay a Monthly Disability Benefit to you while you remain Disabled and otherwise eligible for benefits, but not beyond the end of the Maximum Benefit Period shown in the Schedule of Insurance. Your Maximum Benefit Period for each continuous period of Disability is determined by your age on the date you become Disabled.

A. Elimination Period

Elimination Period means the length of time you must be continuously Disabled and under the Regular Care of a Health Care Practitioner before Monthly Disability Benefits become payable. Your Elimination Period begins on the date you become Disabled. No Monthly Disability Benefits are ever payable for the Elimination Period.

Your Elimination Period is shown in the Schedule of Insurance.

Temporary Recovery during the Elimination Period: For purposes of serving the Elimination Period, all separate periods of Disability from the same cause or causes will be added together and treated as one period of continuous Disability. However, you must serve the full Elimination Period within a period of consecutive days equal to twice the length of the Elimination Period.

B. Maximum Benefit Period

Maximum Benefit Period means the longest period of time for which Monthly Disability Benefits are payable for any one period of continuous Disability (including all combinations of periods of Total Disability and Partial Disability).

Your Maximum Benefit Period for Monthly Disability Benefits is shown in the Schedule of Insurance.

Temporary Recovery during the Maximum Benefit Period: For purposes of continuing Monthly Disability Benefits during the Maximum Benefit Period, any two periods of Disability from the same cause or causes will be added together and treated as one period of continuous Disability if they are separated by a Period of Temporary Recovery of less than 180 days. Thus, a new Elimination Period will not be required, the Prior Earnings used to compute your Monthly Disability Benefits will not change, and the Maximum Benefit Period will be the balance of the Maximum Benefit Period remaining unused before the Period of Temporary Recovery.

If a period of continuous Disability is extended by a new cause while Monthly Disability Benefits are payable, benefits will continue while you remain Disabled (subject to the terms of the Insurance), but not beyond the end of the original Maximum Benefit Period. The exclusions and limitations of the Insurance will apply to the new cause of Disability.

C. Definition of Disability

You will be considered **Disabled** if you are either Totally Disabled or Partially Disabled, as defined in this provision. ***Payment of Monthly Disability Benefits while you are Partially Disabled is limited to six months during any one period of continuous Disability.*** Your Own Occupation Period is shown in the Schedule of Insurance.

1. Total Disability

You will be considered **Totally Disabled** *during* your Own Occupation Period if you are unable, as a result of your Medical Condition, to perform the Substantial and Material Duties of your Own Occupation, you are under the Regular Care of a Health Care Practitioner, and you are not working.

You will be considered **Totally Disabled** *after* your Own Occupation Period if you are unable, as a result of your Medical Condition, to perform the Substantial and Material Duties of any Reasonable Occupation, you are under the Regular Care of a Health Care Practitioner, and you are not working.

2. Partial Disability

You will be considered **Partially Disabled** *during* your Own Occupation Period if you satisfy both of the following conditions:

- a. You are working in your Own Occupation or a Reasonable Occupation and you are unable, as a result of your Medical Condition, to earn at least 85% of your Prior Earnings from work in your Own Occupation; and
- b. You are under the Regular Care of a Health Care Practitioner.

You will be considered **Partially Disabled** *after* your Own Occupation Period if you satisfy both of the following conditions:

- a. You are working in your Own Occupation or a Reasonable Occupation and you are unable, as a result of your Medical Condition, to earn at least 85% of your Prior Earnings from work in your Own Occupation or a Reasonable Occupation; and
- b. You are under the Regular Care of a Health Care Practitioner.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation because of a reduction in your Earnings due to a change in economic conditions or other factors which are not directly related to your Medical Condition.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation solely because of the loss, suspension, restriction, or surrender of your license to engage in the occupation.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation solely because of your inability to work more than 40 hours per week in the occupation.

You will not be considered Disabled from work in your Own Occupation or a Reasonable Occupation if you are able to perform all of the Substantial and Material Duties of the occupation with a Reasonable Accommodation by an employer.

Reasonable Accommodation means changes to the work environment, equipment, or duties of the job which will enable you to perform the job and which can be made without undue hardship to the employer, as required by the federal Americans with Disabilities Act (ADA).

Own Occupation means an occupation of the same general type as the job you were performing when you became Disabled. Your Own Occupation is not limited to the specific job you were performing when you became Disabled or to work at the same location or for the same employer. If you are not working when you become Disabled, your Own Occupation means any Reasonable Occupation.

Reasonable Occupation means any occupation for which you are reasonably fitted by education, training, and experience.

Substantial and Material Duties means the duties which are normally required for the performance of an occupation and which cannot be reasonably omitted or modified.

D. Amount of Monthly Disability Benefit

The amount of your Monthly Disability Benefit is calculated as follows:

Step 1: We will pay the maximum amount of the Monthly Disability Benefit shown in the Schedule of Insurance to you for each month when you are Disabled and otherwise eligible for benefits, unless there is a reduction under Step 2 or Step 3.

Step 2 (Integration with Social Insurance Disability Benefits): Your Monthly Disability Benefit will be reduced by the amount of your Social Insurance Disability Benefits.

Social Insurance Disability Benefits means benefits payable to you, your spouse, or your dependents because of your disability under one or more of the following programs:

1. The United States Social Security Act, the Railroad Retirement Act, or any similar plan or act of any country;
2. The Jones Act, the Federal Employees Liability Act, a Workers Compensation Act, an Occupational Disease Law, or any similar act or law of any jurisdiction providing coverage for occupational disabilities;
3. Any state unemployment compensation disability benefit law or state disability income benefit law, or any similar act or law of any jurisdiction providing coverage for non-occupational disabilities; or
4. Any disability or retirement plan established under state or federal law or the laws of any country for government employees, including but not limited to a public employee retirement system or a state teacher retirement system.

The Social Insurance Disability Benefits used to reduce the amount of your Monthly Disability Benefit will not include any cost of living increase which becomes effective while you are Disabled and while you are eligible to receive the Social Insurance Disability Benefits.

Step 3 (Reduction because of Partial Disability): If you have Earnings from work and satisfy the definition of Partial Disability, the amount of your Monthly Disability Benefit while you are eligible for benefits will be one half (50%) of the maximum amount of your Monthly Disability Benefit (from Step 1). Your Monthly Disability Benefit will not be reduced by the amount of your Social Insurance Disability Benefits, if any. *Payment of Monthly Disability Benefits while you are Partially Disabled is limited to six months during any one period of continuous Disability.*

If your Earnings from work while you are Partially Disabled are less than or equal to 15% of your Prior Earnings, you will be considered Totally Disabled, and the amount of your Monthly Disability Benefit will not be reduced under this Step 3.

Step 4: Your **Minimum Monthly Disability Benefit** is \$200 for each month when you are eligible for a Monthly Disability Benefit under the terms and conditions of your Insurance (including the Earnings Limitation in the Exclusions and Limitations section), even if the amount determined under Step 2 or Step 3 would otherwise be less than \$200.

If a Monthly Disability Benefit is payable for part of a month, the Monthly Disability Benefit will equal the number of calendar days for which benefits are payable times 1/30th of your Monthly Disability Benefit.

E. Definitions of Earnings and Prior Earnings

Earnings means your monthly rate of taxable income from work you perform. Earnings are determined in the same way that earnings are reported to the Internal Revenue Service (IRS). However, Earnings do not include the amount of any money received by fraud or by engaging in any illegal activity or occupation, even if reported to the IRS as taxable income.

Your Earnings include the following categories of income earned by you and reported or reportable by you on your federal income tax return:

1. Salary, wages, fees, commissions, and bonuses;
2. Tax deferred contributions you make to a qualified plan sponsored by an employer;
3. Net profit from a sole proprietorship;
4. Net farm profit from any farm in which you have an interest;
5. Business income from any partnership, limited liability company, or other business entity in which you have an interest; and
6. Ordinary income from any "S" Corporation in which you have an interest, as shown on Schedule K-1 to IRS Form 1120S, as amended or replaced.

Your Earnings do not include the following amounts:

1. Dividends, interest, rent, royalties, and other income earned from passive investment activities;
2. Income from any annuity, pension, or deferred compensation plan; or
3. Usual and customary business expenses which are attributable to the work you perform and which reduce your taxable income as reported to the IRS.

Accounting method: If you use the cash accounting method to report your taxable income to the IRS, your income will be counted as Earnings when it is received. If you use the accrual method to report your taxable income to the IRS, your income will be counted as Earnings when it is accrued. The same accounting method will be used for your Earnings while Disabled as for Prior Earnings.

Prior Earnings means an amount equal to A or B, whichever is greater, where:

- A = Your average monthly Earnings during the full tax year prior to the date you become Disabled
- B = Your average monthly Earnings during the 12 full calendar months prior to the date you become Disabled

Part 2. EXCLUSIONS AND LIMITATIONS

A. War

You are not covered for a Disability resulting from War or any act of War.

War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Military Service

You are not covered for a Disability which begins while you are an active member of the armed forces of any country.

C. Preexisting Conditions

You are not covered for a Disability resulting from a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, your Insurance has been continuously in effect for at least 24 months.

This Preexisting Condition exclusion will also apply to any increase in the amount of your Insurance as a result of a change to your Insurance or your purchase of an optional coverage rider which becomes effective after the Effective Date of your Insurance.

Preexisting Condition means a Medical Condition or symptoms of a Medical Condition for which you have done any of the following, or for which a reasonable and prudent person would ordinarily have done any of the following, at any time during the 24-month period just before the Effective Date of your Insurance:

1. Consulted a Health Care Practitioner;
2. Received medical treatment or services; or
3. Taken insulin or prescribed drugs or medications.

This definition of Preexisting Condition does not include any Medical Condition which you disclosed to us in your Application for Insurance, if required to become insured.

For purposes of applying this Preexisting Condition Exclusion to the continuation of an earlier period of Disability, any two periods of Disability resulting from the same Preexisting Condition will be added together and treated as one period of continuous Disability if they are separated by a Period of Temporary Recovery of less than 180 days.

D. Excluded Medical Conditions

If you are not covered for a Disability resulting from an excluded Medical Condition, the excluded Medical Condition will be shown on an attached Waiver which you have acknowledged in writing.

E. Self-Inflicted Injury

You are not covered for a Disability resulting from an intentionally self-inflicted injury or your attempt to commit suicide.

F. Organ Donor

You are not covered for a Disability or other loss resulting from your voluntary donation of an organ unless, on the date you become Disabled, your Insurance has been continuously in effect for at least six months. Thereafter, payment of Monthly Disability Benefits is limited to six months of Monthly Disability Benefits for each period of Disability resulting from your voluntary donation of an organ. See also the Organ Donor Benefit provision.

G. Regular Care of a Health Care Practitioner

You must be under the Regular Care of a Health Care Practitioner during your Elimination Period. No Monthly Disability Benefits will be paid for any period of Disability when you are not under the Regular Care of a Health Care Practitioner.

Regular Care means that you must see a Health Care Practitioner as often as is medically necessary to effectively manage and treat your Medical Condition in accordance with generally accepted medical standards and that you must receive the most appropriate treatment and care for your Medical Condition in accordance with generally accepted medical standards.

Health Care Practitioner means a licensed medical professional diagnosing and treating your Medical Condition within the scope of the license. The Health Care Practitioner providing Regular Care and treatment for your Medical Condition must be a Health Care Practitioner whose specialty or experience is most appropriate for your Medical Condition, in accordance with generally accepted medical standards. The Health Care Practitioner providing Regular Care and treatment for your Medical Condition cannot be you, your parent, your grandparent, your spouse, your child, your sibling, or any person related to you to the same degree by marriage, anyone living in your household, a business partner, or an employee of your employer.

H. Mental Disorder, Alcoholism, or Drug Addiction

Payment of Monthly Disability Benefits is limited to 24 months of Monthly Disability Benefits during your lifetime for Disability resulting from a Mental Disorder, alcoholism, drug addiction, chemical dependency, or the use of any hallucinogen. However, if you are confined in a Health Care Facility at the end of the 24 months, this limitation will not apply while you remain continuously confined for the treatment of your Mental Disorder, alcoholism, drug addiction, chemical dependency, or use of any hallucinogen.

Mental Disorder means a mental, emotional, or behavioral disorder, regardless of cause, which is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders adopted by the American Psychiatric Association, or its replacement. Mental Disorders are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. Mental Disorders include, but are not limited to, mood disorders including depression and bipolar disorders, anxiety disorders, adjustment disorders, personality disorders, and schizophrenia and other psychotic disorders.

We will not apply the Mental Disorder limitation to the following Mental Disorders:

1. Dementia if it is a result of stroke, trauma, viral infection, Alzheimer s disease, or other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment;
2. Organic brain syndrome;
3. Delirium;
4. Amnesia disorders or organic delusional or hallucinogenic disorders or syndromes;
5. Permanent or progressive cognitive disorders; or
6. Permanent or progressive memory disorders.

Health Care Facility means an accredited hospital or institution licensed to provide care and treatment for your Medical Condition.

I. Normal Pregnancy

No Monthly Disability Benefits will be paid for any period of Disability from a normal pregnancy, elective abortion, or childbirth. We will not apply this limitation to periods of Disability resulting from a Complication of Pregnancy.

Complication of Pregnancy means a sickness which is caused by or contributed to by a pregnancy. It must be diagnosed as distinct from a normal pregnancy.

J. Felony or Violent Conduct

You are not covered for a Disability resulting from your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot while performing your official duties.

K. In Jail

We will not pay benefits for Disability for any period when you are confined for any reason in a jail, prison, or correctional institution. This rule will only apply if you are confined for at least 30 days.

L. Earnings Limitation

No Monthly Disability Benefits will be paid for any period when your Earnings exceed 85% of your Prior Earnings.

M. Partial Disability

Payment of Monthly Disability Benefits while you are Partially Disabled is limited to six months during any one period of continuous Disability.

Part 3. OTHER BENEFITS AND PROVISIONS AFFECTING BENEFITS

A. Organ Donor Benefit

If you are an organ donor, we will pay Monthly Disability Benefits for up to six months for a period of Disability resulting from your voluntary donation of an organ, provided that your Insurance has been in effect for at least six months before you become Disabled. See also the Organ Donor limitation.

B. Return to Work Services

We may provide return to work services and additional financial incentives to help you return to work to the extent of your ability. We will review your claim for Monthly Disability Benefits to determine if return to work services might help you return to gainful employment. If we determine that return to work services are appropriate, we may provide, at our sole discretion, one or more of the following services:

1. Evaluation of adaptive equipment to allow you to work in your Own Occupation or a Reasonable Occupation;

2. Evaluation of possible workplace modifications which might allow you to return to work in your Own Occupation or a Reasonable Occupation;
3. Vocational evaluation to determine how your disability may impact your ability to work in your Own Occupation or a Reasonable Occupation;
4. Job placement services, including resume preparation services and training in job seeking skills;
5. Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance your ability to work;
6. Payment of a medical or prosthesis expense, education expense, or moving expense to make it possible for you to work and for which no other reimbursement is available to you;
7. Payment of Reasonable Accommodation expenses to allow you to work in your Own Occupation or a Reasonable Occupation; or
8. Payment of training or retraining expenses to enable you to return to work in a Reasonable Occupation.

C. Waiver of Premium

After the first 90 days of a continuous period of Disability, your Insurance in effect when you became Disabled will be continued without further payment of premiums while you remain continuously Disabled. If you qualify for this benefit, any premiums due and paid for the first 90 days of the continuous period of Disability will be refunded after you have been continuously Disabled for 90 days. This benefit is subject to the Exclusions and Limitations of this Policy and will end on the date Monthly Disability Benefits end (even if you remain continuously Disabled beyond that date). When you are no longer eligible for this benefit, you may continue your Insurance in force by resuming payment of the premiums as they become due.

D. Benefits After Insurance Ends or is Changed

Your right to receive benefits under this Insurance for a period of continuous Disability which begins while your Insurance is in effect will not be affected by the termination or amendment of your Insurance for any reason after the start of the period of continuous Disability.

Part 4. APPLICATIONS, TERMINATION, PREMIUMS, AND REINSTATEMENT

A. Becoming Insured

You must apply for Insurance. Your Insurance will become effective on the date shown in the Schedule of Insurance, provided that the initial premium payment is received by us within 30 days after the Effective Date of your Insurance and that you are not Disabled on the date we receive your first premium payment.

Application for Insurance means a form completed and signed by you, together with your signed authorization for us to obtain information about your health, finances, and other insurance coverage.

Note: If you paid money with your Application for Insurance, you may have qualified for limited coverage with an earlier effective date, in accordance with the terms of the Conditional Receipt. See your Conditional Receipt.

Conditional Receipt means an acknowledgment of your submission of a premium payment with your Application for Insurance and the description of the limited insurance coverage provided to you until our Underwriting Department has acted on your Application for Insurance.

B. When Insurance Ends

Your Insurance will end automatically on the earliest of the following dates:

1. The date you become a full-time member of the armed forces of any country;
2. The date following the end of the 31-day Grace Period if you fail to pay the required premium for your Insurance by the end of the 31-day Grace Period;
3. The date on or after your 65th birthday when you cease to be regularly scheduled to work at least 30 hours each week for an employer or in self-employment; or
4. The date you become age 70.

C. Premiums

Premiums are due on the first day of the period for which they are payable. Premiums are payable for as long as your Insurance is in effect but not beyond the end of the Premium Payment Period shown in the Schedule of Insurance.

If the premium charges for your Insurance are billed directly to you, the premium statement will be mailed to you at the address shown on your Application for Insurance or to your last known address on the date of the mailing.

Premium Refund at Death: If you die while your Insurance is in force, we will refund the pro rata, unearned portion of any premium paid. We will compute the refund from the end of the Policy month during which you died. The premium refund will be paid to your estate.

The amount of the premium for your Insurance is determined by your age and Rate Class on the Effective Date of your Insurance, as shown in the Schedule of Insurance.

Your Initial Annual Premium and Premium Payment Mode are shown in the Schedule of Insurance. We have the right to change the premium rates for all insureds in the same rate class on any premium due date. We will give you at least 60 days prior written notice of a change in your premium rates. No increase to your premium rate will become effective before your Insurance has been in effect for one year.

D. Grace Period

There is a 31-day Grace Period for each premium due after the first premium. If a premium is not paid on or before the premium due date, the premium may be paid during the following 31-day Grace Period. Your Insurance will remain in force during the Grace Period and you will be liable to us for the payment of the premium for that period. If the required premium for your Insurance is not paid during the Grace Period, your Insurance will terminate automatically at 12:01 A.M. on the date following the end of the Grace Period.

E. Reinstatement

If your Insurance ends because the required premium was not paid during the Grace Period, your Insurance will be reinstated if we accept your premium payment after the end of the Grace Period without requiring an application for reinstatement. If we require an application for reinstatement and issue a Conditional Receipt for the premium tendered, your Insurance will be reinstated when we approve your application for reinstatement or on the 45th day after the date of your application for reinstatement, if we do not give you written notice of our approval or disapproval of your application within 45 days. You must apply for reinstatement of your Insurance within 180 days after the date your Insurance ends. The reinstated Insurance will only cover losses resulting from an accidental bodily injury sustained after the date of reinstatement and losses resulting from a sickness beginning more than ten days after the date of reinstatement. In all other respects our rights under the Policy will be the same as on the last day of the Grace Period, except as reflected in any Policy modification issued in connection with the reinstatement.

F. Your Right to Reinstatement Coverage Following Active Military Service

Your Insurance will end if you become an active full-time member of the armed forces of any country. Active military service does not include periodic training that lasts less than three months at a time, but does include any period when you are called to active duty. You must give us written notice that you have become an active full-time member of the armed forces.

If your military service ends within 60 months after your Insurance ended because of your military service, you will have the right to become insured again within 90 days after your military service ends. No evidence of insurability will be required. You must notify us of your desire to resume your Insurance coverage and pay the required premium within 90 days after your military service ends.

The Preexisting Condition exclusion will apply to your new period of Insurance coverage.

Part 5. HOW TO CLAIM BENEFITS

A. Payment of Benefits; Time of Payment

All benefits will be paid to you unless you send us a written request designating another person to receive benefits payable under this Policy. Any benefits remaining unpaid at your death will be paid to your estate.

All benefits payable under your Insurance will be paid within 30 days after we receive satisfactory written proof of loss in connection with the claim for benefits. All accrued Monthly Disability Benefits will be paid at least once a month during the continuance of the period for which the benefits are payable. Any benefits remaining unpaid at the end of that period will be paid as soon as possible after the receipt of satisfactory written proof of loss in connection with the claim for benefits.

B. Notice of Claim and Time Limits for Filing a Claim

We encourage you to notify us of your claim as soon as possible so that a decision on your claim can be made. You should send us written notice of your claim within 31 days after the date you become Disabled or have another loss, or as soon as reasonably possible. If you have a cognitive impairment, your primary care giver or conservator can provide us with notice of your claim.

You must claim benefits by providing satisfactory written proof of loss to support your claim within 90 days after the date that benefits become payable or as soon thereafter as reasonably possible and, in any case, within one year after the end of that 90-day period. If your claim is not filed within these time limits, then your claim will be denied and no benefits will be paid. These limits will not apply during any period when you lacked the legal capacity to file a claim. If you have a cognitive impairment, your primary care giver or conservator can provide us with proof of loss to support your claim.

C. Claim Forms

Your claim for benefits should be submitted on our forms. We will send claim forms to you after we receive notice of your claim.

If you do not receive the claim forms within 15 days of the date you give us notice of your claim, you may submit your claim to us in a letter stating the occurrence, character, and extent of your Medical Condition or the event for which the claim is made.

D. Proof of Loss

No benefits will be paid unless you provide us with satisfactory written proof of loss at your expense. Once your claim is approved, no benefits will be continued beyond the end of the period for which you have provided us with satisfactory written proof of loss at your expense.

To provide us with satisfactory written proof of loss, you must provide us with the following documents at your expense unless we agree to waive written documentation of information we receive in another way, such as information received electronically or by telephone:

1. A completed claim form signed by you;
2. A completed claim statement signed by your Health Care Practitioner;
3. Your written authorization for us to obtain the records and information (including tax returns) we need to determine your eligibility for benefits, including information from Health Care Practitioners, hospitals, employers, other insurance carriers, and information bureaus; and
4. Any other documents we may reasonably require to evaluate your claim.

If you have a cognitive impairment, your primary care giver or conservator can provide us with proof of loss to support your claim.

We will require you to submit additional documentation of your claim at your expense at reasonable intervals while you are claiming benefits.

Proof of Earnings and Prior Earnings: If you claim Monthly Disability Benefits, we will require satisfactory proof of your Earnings while you are Disabled and, in order to determine your Prior Earnings, for a period not to exceed five years prior to the date you become Disabled. This proof may include, but is not limited to, your complete individual and business federal income tax returns, Internal Revenue Service (IRS) Forms 1040, 1065, 1120S, and 1120, as amended or replaced, with all supporting schedules and documentation. Any financial statements, business or professional records of Earnings, other tax records and financial data accepted by us and used as a basis of making monthly benefit payments to you are subject to verification with federal income tax returns as reported to the IRS.

Proof of Disability: Proof of ongoing Disability must be furnished monthly, unless we send you written notification that proof is required less frequently. The required proof must include monthly claim progress reports completed by you and your Health Care Practitioner.

E. Investigation of Your Claim and Independent Examination of You

We have the right at any time to investigate your claim. We have the right to require that you meet with one of our staff or a person we choose for a personal interview. We will meet with you at reasonable times and not more often than we need to in order to make a decision on your claim. We have the right to review records from your work to help us make a decision on your claim. We may look at your employment or payroll records, financial statements from a business entity where you work or did work, and other business or professional records that show your work Earnings and what you are able to do. We have the right to receive a copy of these records or to look at these records during regular business hours at the business location where the records are maintained.

We have the right to have you examined by one or more Health Care Practitioners or work rehabilitation specialists of our choice while you are claiming benefits for Disability. If we require you to see a Health Care Practitioner or other person of our choice, the visit and all tests will be at our expense. The testing we require may include a physical or mental exam, a review of your functional capacity, and all related tests that we need to conduct a full review of your claim.

We have the right to defer or suspend benefits if you fail to show up for an examination we schedule for you or if you fail to cooperate in good faith with the person who does the testing. In such a case, benefits may be paid later or start again if the required testing is done within a reasonable time and we conclude that benefits are due to you.

F. Your Duty to Cooperate with Us; Our Duty to Communicate with You

You must cooperate with us as we evaluate your claim for benefits. If we believe you may be eligible for benefits under any Social Insurance Disability Benefits program, you must apply for those benefits and pursue any required appeals if there is a reasonable chance of success on appeal.

If you file a claim for benefits with us, a contact person will be assigned to coordinate the evaluation of your claim and to answer any questions you may have. If we are unable to approve or deny your claim for benefits within 15 days, we will give you written notice that we need more time to evaluate your claim. The written notice will include the reason for the delay and will tell you if there is any additional information or documentation you must submit to obtain benefits.

G. Notice of Decision on Your Claim; Your Right to Review

We will give you a written notice of our decision on your claim within 15 days after we receive the required proof of loss on your claim or, if we notify you that we need more time to evaluate your claim, within 30 days after we receive your proof of loss. If we deny all or any part of your claim, we will give you the following information in writing:

1. We will give you the reasons for our denial of all or any part of your claim;

2. We will refer to the wording of your Insurance which is the basis for the denial of all or any part of your claim; and
3. We will describe the additional information, documents, or proof of loss you must submit to obtain benefits and explain why we need more information in order to pay your claim.

You have a right to a review of any denial by us of all or any part of your claim. To obtain a review, you should send a written request for review to us within 60 days after you receive notice of the denial. No special form is required. As a part of your request for a review, you may submit issues and comments in writing and give us more information, documents, and proof of loss in support of your claim. If you have a cognitive impairment, your primary care giver or conservator can request a review of your claim. You may review pertinent documents related to your request for review. We will review your claim promptly after receiving your request for review. You will receive written notice of our decision within 60 days after your written request for review is received.

H. Time Limits on Legal Actions

You cannot start any legal action against us for benefits until at least 60 days after we have received written proof of loss in support of your claim. You also cannot start any legal action against us without first exercising your right to request that we review our denial of all or any part of your claim or more than three years after the time limit for giving us proof of loss in support of your claim has expired.

I. Misstatement of Age or Gender

If your age or gender has been misstated, any benefits payable under your Insurance will be adjusted to equal the benefits the premiums paid would have purchased at the correct age or gender, and your rate class will be the rate class based on the correct age or gender.

J. Assignment

You may assign the benefits payable under your Insurance. We are not responsible for the validity of any assignment. No assignment is binding on us until a copy of the assignment is received by us.

Part 6. INCONTESTABLE CLAUSE

Any statement you make to obtain Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider is a representation and not a warranty. We will rely on the statements you make in your application in order to approve your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider. You are responsible for verifying the accuracy of each statement you make to obtain Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider, to the best of your knowledge and belief.

No misrepresentation by you will be used to reduce or deny your claim for loss incurred or Disability commencing while insured or to deny the validity of your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider unless all of the following are true:

1. We would not have approved your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider as issued if we had known the truth;
2. Your misrepresentation is contained in a written document signed by you; and
3. You have been given a copy of the written document containing your misrepresentation.

After your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider has been in effect for two years during your lifetime, we will not use a misrepresentation by you, unless it was a fraudulent misrepresentation, to reduce or deny your claim for loss incurred or Disability commencing after the expiration of the two-year period or to deny the validity of your Insurance, a reinstatement of your Insurance, a change to your Insurance, or an optional coverage rider.

Part 7. THE CONTRACT

A. Entire Contract; Changes

The entire contract between you and us consists of this Policy, the application, any supplemental applications, and any attached papers prepared by us which state that they become a part of the Policy.

The Policy may be changed in whole or in part, subject to the following rules: No change in the Policy which reduces or eliminates coverage will be valid unless it is requested in writing or accepted in writing by you and approved by one of our executive officers. No change to this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to you for attachment to this Policy.

No agent has the authority to change the Insurance of any Insured.

B. Conformity with State Statutes

Any provision of this Policy which is in conflict with the laws of the Issue State in effect on the Effective Date of your Insurance is amended to conform to the minimum requirements of the laws of the Issue State in effect on that date.

Part 8. GENERAL DEFINITIONS AND INDEX OF DEFINED TERMS

The defined terms used in this Policy are defined here or in another part of this Policy. The Index of Defined Terms tells you where to find each definition. Except for "you," "your," "we," "us," and "our," all defined terms are printed with an initial capital letter whenever they are used in this Policy. All defined terms have the same meaning wherever they are used in this Policy.

Insurance means the coverage provided for you under this Policy.

Monthly Disability Benefit means the benefits payable under this Insurance because of your Disability.

Medical Condition means your sickness, accidental bodily injury, pregnancy, Mental Disorder, or cognitive impairment.

Period of Temporary Recovery means any time following a period of Disability when we do not consider you Disabled.

We, Us, and Our. See cover page of Policy.

You and Your. See cover page of Policy.

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SPECIMEN

SPECIMEN

**THE
CINCINNATI LIFE INSURANCE COMPANY**

**P.O. BOX 145496, CINCINNATI, OHIO 45250-5496
(513) 870-2000**

**DISABILITY INSURANCE POLICY
Nonparticipating**

Form CLI-507-AR (3/01)