

SERFF Tracking Number: PERR-127032459 State: Arkansas
Filing Company: Beazley Insurance Company, Inc. State Tracking Number: 48032
Company Tracking Number: BICI-DI-AR-11-01-F
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Group Short Term/Voluntary Short Term Disability Income
Project Name/Number: BICI-DI-AR-11-01-F/BICI-DI-AR-11-01-F

Filing at a Glance

Company: Beazley Insurance Company, Inc.

Product Name: Group Short Term/Voluntary Short Term Disability Income SERFF Tr Num: PERR-127032459 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 48032

Sub-TOI: H11G.002 Short Term

Filing Type: Form

Co Tr Num: BICI-DI-AR-11-01-F State Status: Approved-Closed

Reviewers: Rosalind Minor

Disposition Date: 03/01/2011

Authors: Lois Pimentel, Addy Anggelico

Date Submitted: 02/18/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: BICI-DI-AR-11-01-F

Project Number: BICI-DI-AR-11-01-F

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association

Filing Status Changed: 03/01/2011

State Status Changed: 03/01/2011

Created By: Lois Pimentel

Corresponding Filing Tracking Number: Exempt

Filing Description:

On behalf of Beazley Insurance Company, Inc (the "Company"), we are introducing a new Group Short Term/Voluntary Short Term Disability Income program.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Addy Anggelico

Please refer to the enclosed memorandum for additional details. Please note that the rates are exempt from filing requirements.

We respectfully request this filing to be effective the earliest possible date according to filing law.

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Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. The Company has prepared the forms contained within this filing. All correspondence related to this filing should be directed to Perr&Knight. If there are any requests for additional information related to items prepared by the Company, we will forward the request immediately to the Company. We will submit the Company's response to your attention as soon as we receive it.

Please do not hesitate to contact us with any questions or comments.

Company and Contact

Filing Contact Information

Lois Pimentel, State Filings Project Coordinator doi@perrknight.com
 Perr&Knight 707-546-6896 [Phone]
 881 Alma Real Drive, Suite 205 310-230-8529 [FAX]
 Pacific Palisades, CA 90272

Filing Company Information

(This filing was made by a third party - perrandknightactuaryconsultants)

Beazley Insurance Company, Inc.	CoCode: 37540	State of Domicile: Connecticut
20 Stanford Drive	Group Code: -99	Company Type:
Farmington, CT 06032	Group Name:	State ID Number:
(860) 677-3707 ext. [Phone]	FEIN Number: 04-2656602	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$250.00
Retaliatory?	No
Fee Explanation:	\$50 per form x 5 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Beazley Insurance Company, Inc.	\$250.00	02/18/2011	44875979

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/01/2011	03/01/2011

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Disposition

Disposition Date: 03/01/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization letter	Approved-Closed	Yes
Supporting Document	Filing Memorandum	Approved-Closed	Yes
Supporting Document	Statements of Variability	Approved-Closed	Yes
Form	ENROLLMENT FORM – MEDICAL HISTORY	Approved-Closed	Yes
Form	ENROLLMENT FORM	Approved-Closed	Yes
Form	CERTIFICATE OF INSURANCE	Approved-Closed	Yes
Form	APPLICATION FOR GROUP INSURANCE	Approved-Closed	Yes
Form	MASTER POLICY	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 03/01/2011	AHDIA0003 102010 Ed.	Application/ Enrollment Form	ENROLLMENT FORM – MEDICAL HISTORY	Initial		0.000	DI Enrollment Form Medical History FINAL.pdf
Approved- Closed 03/01/2011	AHDIA0002 102010 Ed.	Application/ Enrollment Form	ENROLLMENT FORM	Initial		0.000	DI Enrollment Form FINAL.pdf
Approved- Closed 03/01/2011	AHDIC000 1-AR 102010	Certificate Ed.	CERTIFICATE OF INSURANCE	Initial		0.000	AR Certificate.pdf
Approved- Closed 03/01/2011	AHILA0001 102010 Ed.	Application/ Enrollment Form	APPLICATION FOR GROUP INSURANCE	Initial		0.000	DI CI Group Application FINAL.pdf
Approved- Closed 03/01/2011	AHDIM000 1-AR 102010	Policy/Cont ract/Fratern al Ed.	MASTER POLICY Certificate	Initial		0.000	AR Policy.pdf

<Beazley Name Logo>

Use this form to apply or make changes to the coverage listed below. **Late applicants are subject to full medical underwriting.**

Beazley Insurance Company, Inc.

Administrative Office
[Address here]

[EMPLOYEE / MEMBER] ENROLLMENT FORM – MEDICAL HISTORY
Group Disability Income Application

[EMPLOYEE / MEMBER] INFORMATION

Last Name	First Name	M.I.	Social Security #	Date of Birth
Street Address	Apt. No.	City	State	Zip Code
Home Phone ()	Work Phone ()	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Height: ___ Ft. ___ In.	Weight: ___ Lbs.	Name of Primary Physician: Address:		Date last consulted:
[Employer or Group/Association Name]			[Division or Department]	

REQUEST FOR MEDICAL INFORMATION

The health questions below pertain to you, the applicant. If "Yes" is answered to any question, or if your height/weight profile is beyond acceptable parameters, you will not be eligible for insurance under the Policy.

1. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last five years, have you been treated (including medication) for, or been diagnosed with, or sought treatment from a member of the medical profession for: ALS (Lou Gehrig's Disease), Alcohol or Drug Abuse; Bone or Joint Disorder; Cancer (except basal cell carcinoma); Congestive Heart Failure; Carpal Tunnel Syndrome; Chronic Fatigue Syndrome; Cirrhosis; Crohn's Disease; Diabetes; Epilepsy; Heart Attack/Heart Surgery; Hepatitis B or C; High Blood Pressure; Hodgkin's Disease; Major Depressive Disorder; Muscular Disorder; Muscular Dystrophy; Multiple Sclerosis; Paralysis; any injuries or chronic pain associated with the Spine, Neck or Back; Stroke, Transient Ischemic Attack (TIA); or Systemic Lupus Erythematosis (SLE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been hospitalized in the last 90 days (for any reason) or been recommended to seek: a) medical advice, b) treatment, c) care, and/or d) counseling that has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURE (This form must be signed)

AUTHORIZATION AND ACKNOWLEDGMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and I understand that they are the basis on which insurance requested by me may be issued.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me [or my beneficiary]. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

[I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected.]

Please continue to read below for special notices required by state law.

X _____
Signature of Proposed Insured

Date Signed

FRAUD WARNING

[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.]

[Arkansas, Louisiana, West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

[Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.]

[Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.]

[Maryland, Oregon – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[New Jersey - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[New Mexico - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Ohio – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[Oklahoma – 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 is guilty of a felony.]

[Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of

misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

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

[Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

<Beazley Name Logo>

Use this form to apply or make changes to the coverage listed below. **Late applicants are subject to full medical underwriting.**

Beazley Insurance Company, Inc.
Administrative Office
[Address here]

[EMPLOYEE / MEMBER] ENROLLMENT FORM
Group Disability Income Application

A. [EMPLOYEE / MEMBER] INFORMATION				
Last Name	First Name	M.I.	Social Security #	Date of Birth
Street Address	Apt. No.	City	State	Zip Code
Home Phone ()	Work Phone ()	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
[Employer or Group/Association Name]		[Division]	Job Title / Employment Date	
Are you currently Actively at Work and able to perform the duties of your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many hours are you regularly working per week with your current employer? _____ hours per week	Please list your salary received during the prior 12 months from your current employer: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly		
Insurance Requested: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Status Change: (Family status / Address / Name / Other)			Date:	

B. REQUESTED BENEFIT AMOUNTS		
Will the coverage applied for with this enrollment application <i>replace</i> existing disability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will the coverage applied for with this enrollment application <i>supplement</i> any disability income coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No
[Weekly, Monthly] Benefit Amount (in \$100 increments) – not to exceed the plan maximum [monthly, weekly] benefit [percentage of _____%] [or] [amount of \$ _____]: \$ _____	MAXIMUM AMOUNT OF INSURANCE WITHOUT REQUIRING EVIDENCE OF INSURABILITY IS [\$3,000 WEEKLY, \$10,000 MONTHLY] <i>If you are applying for an amount over [\$3,000, \$10,000], you must complete a Medical History form.</i>	

[NAME OF BENEFICIARY _____]

C. SIGNATURE (This form must be signed)

AUTHORIZATION AND ACKNOWLEDGMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me [or my beneficiary]. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

[I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected.] [I further understand that a disability which results from a pre-existing condition will not be covered if the disability begins within 12 months after the effective date of insurance.]

Please continue to read below for special notices required by state law.

X _____
Signature of Proposed Insured

Date Signed

FRAUD WARNING

[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.]

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<Beazley Name Logo>

INSURER NAME:	Beazley Insurance Company, Inc.
INSURER ADDRESS: ADMINISTRATIVE OFFICE	[30 Batterson Park Road Farmington, CT 06032]
INSURER ADDRESS: NOTICE OF CLAIM	[30 Batterson Park Road Farmington, CT 06032]

CERTIFICATE OF INSURANCE

Beazley Insurance Company, Inc. (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. It becomes your Certificate of Insurance only if: 1) You are eligible for the insurance; 2) You are on Active Service on the date it is to take effect; and 3) You become insured and remain insured in accordance with the provisions of the Policy. The insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. No agent may change the Policy or waive any of its provisions.

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

[
Secretary
]

[
President
]

NON-PARTICIPATING GROUP DISABILITY INCOME CERTIFICATE

[FIFTEEN DAY RIGHT TO EXAMINE CERTIFICATE

If You decide that You do not want this Certificate for any reason, You may return it to Us within fifteen (15) days after the date You receive it [.] [for a full refund of any premium paid.] When it is returned, it will be considered void as though it were never issued.]

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.

[The coverage under this Certificate contains an exclusion for pre-existing conditions. Read your Certificate carefully.]

This Certificate [does] [does not] cover disabilities due to an occupational Accident or Sickness.

IMPORTANT CANCELLATION INFORMATION – Please read the provision entitled Termination of Insurance

**The Policy is a contract between the Policyholder and the Company.
READ YOUR CERTIFICATE CAREFULLY**

TABLE OF CONTENTS

Schedule of Benefits 3

Definitions 4

Eligibility and Effective Date..... [8]

Disability Benefits..... [10]

Limitations [15]

Exclusions [17]

Termination of Insurance [18]

Premium Calculation and Payment..... [19]

General Provisions..... [21]

SCHEDULE OF BENEFITS

[PLAN: [1]]

INSURED NAME:	[John Doe]	CERTIFICATE NUMBER:	[XXXXXX]
CERTIFICATE EFFECTIVE DATE:	[10/15/2010]	ISSUE AGE:	[60]
POLICYHOLDER NAME:	[XYZ Company, Inc]	POLICYHOLDER NUMBER:	[XXXXXX]

ELIGIBILITY: [ALL [PERMANENT] [MEMBERS] [AND] [EMPLOYEES], BETWEEN THE AGES OF 18 AND 64, WORKING [25] HOURS OR MORE PER WEEK AND ON ACTIVE SERVICE.]

DISABILITY BENEFIT:[\$10,000.00] [Monthly]

MINIMUM DISABILITY BENEFIT:[\$300.00] [Monthly]

MAXIMUM BENEFIT PERIOD: [60] [Months]

[MAXIMUM MENTAL ILLNESS PERIOD: [24] [Months]]

[MAXIMUM PARTIAL DISABILITY BENEFIT PERIOD..... [24] [Months]]

[SURVIVOR BENEFIT..... [3] [Months]]

ELIMINATION PERIOD:

ACCIDENT: [30 days]

SICKNESS: [30 days]

WAITING PERIOD: [30 days]

[PRE-EXISTING CONDITION PERIOD: [3 Months]]

RECURRENT DISABILITY PERIOD: [3 Months]

RATE GUARANTEE PERIOD: [3 Years]

[MAXIMUM PORTABILITY PERIOD: [24 Months]]

[INITIAL [MONTHLY] PREMIUM [\$9.99]]

DEFINITIONS

ACCIDENT (or Accidental Injury) means an injury You sustain:

- (1) that is independent of any Sickness;
- (2) over which You have no control;
- (3) that takes place while Your coverage is in force; and
- (4) that is a direct cause of a disability.

If the period of disability begins more than 60 days after an Accident, the disability will be considered to have been caused by a Sickness.

ACTIVE SERVICE means that You are:

- (1) performing in the usual manner, all of the Material and Substantial Duties of Your Own Occupation for the regularly scheduled number of hours on a scheduled work day; and
- (2) the Material and Substantial Duties are being performed at one of the places of business where You normally perform such duties or at some location to which Your employment sends You.

You will be said to be on Active Service on a day that is not a scheduled work day only if You are 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 BENEFIT means the benefit amount, prior to the application of Limitations, for which You are eligible and for which premium has been paid.

EARNED INCOME means Your gross earnings from Your personal participation in any occupation(s), profession(s) or business(es). If Your Own Occupation involves ownership of any portion of any profession(s) or business(es), including any corporation, Earned Income includes Your share of the earnings of such profession(s) or business(es) reduced by any amount that is deductible as a business expense for federal income tax purposes. Earned income does not include investment income, deferred compensation or retirement income.

EFFECTIVE DATE means the date described in the Policy. The date shown in Your Certificate will be the 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, as listed in the Schedule, that starts after Your Effective Date of coverage, during which:

- (1) You are Totally Disabled; and

(2) no Disability Benefits are payable.

GAINFUL EMPLOYMENT means Your Own Occupation, as well as any other occupation or professions for which You are reasonably fitted by education, training or experience.

INSURED (You, Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MATERIAL AND SUBSTANTIAL DUTIES means the duties that:

- (1) are normally required for the performance of Your Own Occupation; and
- (2) cannot be reasonably omitted or modified.

MENTAL ILLNESS means psychiatric or psychological conditions, regardless of cause, including but not limited to:

- (1) schizophrenia;
- (2) depression;
- (3) manic depressive or bipolar illness;
- (4) anxiety;
- (5) personality disorders; and/or
- (6) 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;

that are a direct cause of a disability.

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

- (1) stroke;
- (2) trauma;
- (3) viral infection;
- (4) Alzheimer's disease; or

other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

OWN OCCUPATION means all occupations or professions in which You are regularly engaged for wage or profit at the time You become disabled. An occupation or profession will be defined as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location.

PHYSICIAN means a practitioner of the healing arts who:

-
- (1) is practicing within the scope of his or her license in the state where so licensed; and
 - (2) is not related to You.

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

POLICYHOLDER means the association, employer or other organization who holds the Policy, as listed on the Schedule of Benefits.

[PRE-DISABILITY MONTHLY COMPENSATION means:

- (1) if You are a salaried employee, Your Earned Income for the month preceding the month in which Your Total Disability began; otherwise
- (2) if Your Earned Income fluctuates from month to month because of commissioned sales, tips, overtime pay or bonus earnings, the greater of:
 - (a) one twelfth ($1/12^{\text{th}}$) of the Earned Income for the 12 months preceding the month in which Your Total Disability began; or
 - (b) one twenty-fourth ($1/24^{\text{th}}$) of the Earned Income for the 24 months preceding the month in which Your Total Disability began.]

[PRE-DISABILITY WEEKLY COMPENSATION means:

- (1) if You are a salaried employee, Your Earned Income for the week preceding the week in which Your Total Disability began; otherwise
- (2) if Your Earned Income fluctuates from week to week because of commissioned sales, tips, overtime pay or bonus earnings, the greater of:
 - (a) one fifty-second ($1/52^{\text{nd}}$) of the Earned Income for the 52 weeks preceding the week in which Your Total Disability began; or
 - (b) one one-hundred-fourth ($1/104^{\text{th}}$) of the Earned Income for the 104 week preceding the week in which Your Total Disability began.]

PRE-EXISTING CONDITION means an Accident or Sickness for which You have:

- (a) had treatment;
 - (b) incurred expense;
 - (c) taken medication; or
 - (d) received a diagnosis or advice from a Physician,
- during the Pre-Existing Condition Period indicated in the Schedule of Benefits, immediately before the Effective Date of coverage. The term Pre-Existing Condition will also include conditions that are related to such Accident or Sickness.

RECURRENT DISABILITY means a disability caused by an Accident or Sickness which is the

same as, or related to, the cause of a prior disability for which Disability Benefits were payable under the Policy.

REGULAR CARE AND ATTENDANCE means attended by a Physician at least once a month or until the Physician determines that You:

- (1) have reached Your maximum point of recovery; and
- (2) are still Totally Disabled, as defined in Definitions.

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

SICKNESS means illness or disease that starts while Your coverage is in force and is the direct cause of a disability. Sickness includes pregnancy and any complications of pregnancy, including but not limited to a non-elective cesarean section.

TOTAL DISABILITY (or Totally Disabled) means that, as the result of a covered Accident or Sickness, You are:

- (1) unable to perform the Material and Substantial Duties of Your Own Occupation; and
- (2) under the Regular Care and Attendance of a Physician, whose area of practice is appropriate for the treatment of the Accident or Sickness causing Your disability, based on prevailing medical standards; and
- (3) not working in Gainful Employment.

WAITING PERIOD means the period of time You must be in Active Service as an employee of the Policyholder, member of the Policyholder, or employee of a member of the Policyholder, before You become eligible to enroll for coverage under the Policy.

ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who:

- (1) are in Active Service as
 - [(a) employees of the Policyholder][,]
 - [(b) members of the Policyholder][,]
 - [(c) employees of a member of the Policyholder] [or]
 - [(d) employees of an employer who is obligated to employ persons who are members of the Policyholder];
- (2) qualify as eligible Insureds as defined in the Policyholder's application; and
- (3) 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.

This Policy will allow from time to time, that new eligible Insureds of the Policyholder be added to the eligible classes of Insureds originally insured under the Policy.

EFFECTIVE DATE

Your coverage will take effect on the Certificate Effective Date shown in the Schedule of Benefits.

[[If You are not on Active Service, due to an Accident or Sickness when Your coverage would otherwise take effect, it will take effect on the next premium due date after the date You return to Active Service. If You are not on Active Service when Your coverage would otherwise take effect, coverage will take effect on the first day of the calendar month after the date You return to Active Service, provided that You return to Active Service within 30 days of the proposed Effective Date. If the absence from Active Service extends beyond 30 calendar days, You must complete a new application for coverage.]]

[If You are not on Active Service due to:

- (1) an Accident or Sickness; or
- (2) non-employment by reason of layoff, strike or termination of employment with Your last employer,

when Your coverage would otherwise take effect, coverage will take effect on the next premium due date after the date You return to Active Service, if You return to Active Service within 30 days of the proposed effective date. If the absence from Active Service extends beyond 30 calendar days, You must complete a new application for coverage.]]

A change in the amount of benefits will take effect on the first day of the next month following written notice to Us if:

- (1) such change is approved by Us; and
- (2) You are on Active Service on the date such change is to take effect

subject to the payment of all premiums due.

[However, no increase shall take effect if You are not on Active Service due to non-employment by reason of layoff, strike or termination of employment with Your last employer.]

Any change in the Policy will apply only to new periods of disability that begin after such date, subject to all the provisions of the Policy.

DISABILITY BENEFITS

Disability Benefits will be paid for only one disability when:

- (1) more than one disability exists at the same time; or
- (2) a disability results from two or more causes.

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

[The Company will not pay a benefit for more than one of the following at the same time: Total Disability[,] [and] [Partial Disability] [and] [Residual Disability].]

If the Maximum Benefit Period stated in the Schedule is more than one year in length, the Maximum Benefit Period will be adjusted based on Your age as of the date benefits begin, as follows:

- (1) Subtract the Maximum Benefit Period (number of years) from 70 years, then:
 - (a) If You are younger than this age, benefits will be payable for up to the number of years stated as the Maximum Benefit Period.
 - (b) If You are older than this age, but younger than age 69, benefits will be payable until You attain age 70.
 - (c) If You are age 69 or older, benefits will be payable for up to one year.
- (2) The premium and benefit amount will not change due to a change in the Maximum Benefit Period.

TOTAL DISABILITY BENEFIT

A Total Disability Benefit will be paid if You become Totally Disabled, while Your coverage is in force, for the period of Total Disability that continues beyond the Elimination Period.

No such benefits will be paid beyond the Maximum Benefit Period stated in the Schedule.

The Elimination Period and Maximum Benefit Period apply separately to each period of Total Disability.

[MENTAL ILLNESS LIMITED BENEFIT

If You are Totally Disabled due to a Mental Illness, Disability Benefits will be paid for the period of Total Disability up to the Maximum Mental Illness Benefit Period shown in the Schedule.]

RECURRENT DISABILITY

A Recurrent Disability will be considered part of the prior disability unless separated by Your return to Active Service for at least the Recurrent Disability Period stated in the Schedule of Benefits.

A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability that begins after termination of coverage will not be considered a Recurrent

Disability and will not be covered under the Policy.

[PARTIAL DISABILITY BENEFIT

A Partial Disability Benefit of up to 50% of the Total Disability Benefit will be paid if You become Partially Disabled following a period of Total Disability. However, the sum of the Partial Disability Benefit, Your [monthly] Earned Income while receiving Partial Disability Benefits, and [monthly] income from all other sources listed in Limitations Section may not exceed 80% of Your [Pre-Disability Monthly Compensation]. [In this event, the Minimum Disability Benefit, if any, stated in the Schedule will not be payable.]

Partial Disability Benefits will be payable beginning the first day following the date Total Disability ends. The Partial Disability Benefit will be payable for the period of Partial Disability up to the Maximum Partial Disability Benefit Period shown in the Schedule. However, the combined period of time for which benefits are payable for Total Disability and Partial Disability may not exceed the Maximum Benefit Period stated in the Schedule.

Payment of the Partial Disability Benefit is subject to the following conditions:

- (1) The Elimination Period for Total Disability must be satisfied and Total Disability Benefits payable.
- (2) The Partial Disability must be the result of the same Accident or Sickness which caused Total Disability.

PARTIAL DISABILITY (or Partially Disabled) means that, as the result of a covered Accident or Sickness:

- (1) You are unable to perform one or more of the Material and Substantial Duties of Your Own Occupation, or are able to perform all of the Material and Substantial Duties of Your Own Occupation for no more than 80% of Your regularly scheduled number of hours;
- (2) You are not working in Your Own Occupation;
- (3) You are employed in another occupation; and
- (4) Your [monthly] Earned Income is less than 80% of Your [Pre-Disability Monthly Compensation].]

[RESIDUAL DISABILITY BENEFIT

A Residual Disability Benefit will be paid if You become Residually Disabled following a period of Total Disability. The Residual Disability Benefit will be equal to:

- (1) The Total Disability Benefit, if the sum of Your [monthly] Earned Income while Residually Disabled and [monthly] income from all other sources listed in Limitations Section is less than 20% of Your [Pre-Disability Monthly Compensation];
- (2) Zero, if the sum of Your [monthly] Earned Income while Residually Disabled and [monthly] income from all other sources listed in Limitations Section is more than 80% of Your [Pre-Disability Monthly Compensation];

otherwise,

- (3) The Total Disability Benefit multiplied by the Residual Disability Income Replacement Percentage.

Residual Disability Benefits will be payable beginning the first day following the date Total Disability ends. The combined period of time for which benefits are payable for Total Disability and Residual Disability may not exceed the Maximum Benefit Period stated in the Schedule.

Payment of the Residual Disability Benefit is subject to the following conditions:

- (1) The Elimination Period for Total Disability must be satisfied and Total Disability Benefits payable.
- (3) The Residual Disability must be the result of the same Accident or Sickness which caused Total Disability and for which Total Disability Benefits were payable.

RESIDUAL DISABILITY (or Residually Disabled) means that, as the result of a covered Accident or Sickness:

- (1) You are unable to perform one or more of the Material and Substantial Duties of Your Own Occupation, or are able to perform all of the Material and Substantial Duties of Your Own Occupation for no more than 80% of Your regularly scheduled number of hours;
- (2) You are working in Your Own Occupation; and
- (3) Your [monthly] Earned Income is less than 80% of Your [Pre-Disability Monthly Compensation].

RESIDUAL DISABILITY INCOME REPLACEMENT PERCENTAGE means 100% minus the ratio of the sum of Your [monthly] Earned Income and [monthly] income from all other sources listed in Limitations Section, while Residually Disabled, to Your [Pre-Disability Monthly Compensation].]

[REHABILITATION PROGRAM SERVICES

If You are receiving Disability Benefits, We may offer You participation in a Rehabilitation Program to assist You to return to Gainful Employment. [We have the right to suspend Disability Benefits if You do not participate in the Rehabilitation Program that is offered.]

The Rehabilitation Program will start when a written Rehabilitation Agreement is signed by:

- (1) You;
- (2) Us; and
- (3) the Policyholder, if necessary.

The Rehabilitation Program may include, but is not limited to, the following services:

- (1) vocational assessment of Your work potential;
- (2) treatment programs such as support groups, physical therapy, occupational therapy, and speech therapy
- (3) coordination and transition planning with an employer for Your return to Gainful Employment;
- (4) consulting with Your Physician on Your return to Gainful Employment and need for accommodations or worksite modifications;
- (5) training in job seeking skills and resume preparation;
- (6) retraining; and
- (7) assistance with relocation services.

We will determine if you are eligible for the Rehabilitation Program and amount and nature of services provided under the Rehabilitation Program. We will pay for all services provided under the Rehabilitation Program.]

[SURVIVOR BENEFIT

If You:

- (1) die while receiving Disability Benefits; and
- (2) have been Totally Disabled for at least [180 consecutive days], a Survivor Benefit will be paid to Your beneficiary or estate.

The Survivor Benefit will be paid in a lump sum and will be equal to Disability Benefit that would be payable over the period listed in the Schedule as the Survivor Benefit.]

[DISABILITIES OCCURRING OUTSIDE THE UNITED STATES OR TERRITORIES OF THE UNITED STATES:

If You become Totally Disabled outside the United States or territories of the United States, Disability Benefits due to You will be limited to the lesser of:

- (1) [2 Months]; or
- (2) the Maximum Benefit Period specified in the Schedule of Benefits.

To continue to receive any additional Benefit Payments due to You, You must reside in the United States or a territory of the United States for the duration of the period of Total Disability.]

[PORTABILITY

This Policy provides portability for up to the Maximum Portability Period listed in the Schedule, when Your coverage under the Policy terminates because Your [employment] [or] [membership] with the Policyholder ends; provided:

- (1) You are not disabled, retired or on a leave of absence; and
- (2) You were covered under the Policy [, for at least 12 months in a row,] at the date [employment] [or] [membership] ended. [The 12 months may be a combination of coverage under this Policy, and under any prior group short term disability policy this Policy replaces.]

Portability is not available to You if Your coverage terminates because the Policy is terminated by the Policyholder or Us.

To continue coverage under the Portability provision, written application and the first premium payment must be made within 31 days of the date insurance ends under the Policy.

The coverage continued under the Portability provision is the coverage in effect on the date Your [employment] [or] [membership] ends, including the Disability Benefit, Maximum Benefit Period and Elimination Period. [Continued coverage may not be increased. You may request decreased continued coverage at any time during the continuation period by completing a request form supplied by the Company.]

Coverage under the Portability provision will cease on the earliest of:

-
- [(1) the date the Policy terminates;]
 - (2) the end of the last period for which premium has been paid;
 - (3) the date coverage under this Portability provision has been continued for the Maximum Portability Period listed in the Schedule;
 - (4) the date You retire or die; and
 - (5) the date You are covered under any other group short term disability plan.

Premiums for continued coverage under the Portability provision shall be derived solely from Your contribution. For Portability coverage to become effective and remain in effect, You shall make premium payment for Your continued coverage directly to Us, on or before each premium due date. We will send You a billing statement in advance of each premium due date. You are responsible for paying all premiums as they become due.

The required premium for the continued coverage will equal the premium in effect when Your employment ended [plus a direct billing fee based on premium frequency].]

LIMITATIONS

OTHER INCOME

The Disability Benefits paid to You will be reduced by the payments You are entitled to receive from:

- (1) group insurance coverage or like coverage for persons in a group;
- (2) Federal Social Security Act (this includes benefits paid to You and Your dependents on account of Your disability);
- (3) Federal Old Age Benefits under the Federal Social Security Act on Your own behalf;
- [(4) salary or wage continuance plans such as accrued sick leave or paid personal time used as sick leave, paid for by the Policyholder or Your employer which extend beyond the Elimination Period stated in the Schedule;]
- [(5) Governmental or other retirement system as a result of Your employment, whether due to disability, normal retirement or voluntary election of retirement benefits;]
- [(6) Workers Compensation, Employers' Liability or similar law;]
- [(7) a State disability plan;] and
- [(8)] pension plan to which the Policyholder or Your employer contributes or makes payroll deductions.

If it appears that You are entitled to any of the above income sources (this includes benefits payable to You and Your dependents), unless You show proof to Us that payments under these applicable programs or acts have been applied for, but will not be paid, We:

- (1) will assume You are receiving such payments; and
- (2) may require You to reapply (but not more frequently than annually) once a denial of benefits has been received from any of the above sources, and appeals have been pursued. Failure to reapply for benefits when required by Us will result in Our estimation of payment by those sources.

Benefits will not be reduced due to a cost of living increase in Social Security if the increase takes place while benefits are payable under the Policy.

With respect to any and all of the above sources, if lump sum payment is received by You or Your dependents for a period previously paid by You, any resulting overpayment by Us will be due to Us on a lump sum basis.

If You have the option of taking retirement benefits on a monthly basis, but choose to receive retirement benefits on a lump sum basis, We may assume You are receiving retirement benefits based upon the lowest monthly retirement plan benefit available to You prior to lump sum withdrawal.

Unless stated otherwise, the Disability Benefit payable will be no less than the Minimum Disability Benefit amount set out in the Schedule.

[PRE-EXISTING CONDITION LIMITATION

There will be no Disability Benefit payable for a Total Disability caused or contributed to by, or resulting from a Pre-Existing Condition during the first 12 months of coverage.

[If You were covered under a prior carrier's group disability policy at the date of change in coverage to a group disability policy provided by the Us, and were not subject to a Pre-Existing Condition limitation under the prior carrier's policy, there shall be no Pre-Existing Condition limitation under Our policy. However, if You were subject to a Pre-Existing Condition limitation under the prior carrier's policy, credit will be given toward satisfaction of the Pre-Existing Condition limitation of Our policy for that period of time that You were continuously covered under the prior carrier's policy.]

[Any increase in the amount of Your Disability Benefit [which exceeds an annual increase of \$200.00] will be subject to this Pre-Existing Condition Limitation, beginning on the Effective Date of the increase.]]

EXCLUSIONS

The Policy does not provide benefits for any disability that results from:

- (1) an act of war, declared or undeclared;
- (2) active participation in a riot, civil commotion, civil disobedience or unlawful assembly;
- (3) Accident sustained or Sickness contracted while in the service of the armed forces of any country;
- (4) committing a felony;
- (5) air travel, except as a fare-paying passenger on a commercial airline;
- (6) taking part in a contest of speed, parachuting or hang gliding;
- (7) participation in a sport for compensation or profit;
- (8) elective surgery (with the exception of organ donation) or cosmetic surgery, unless due to a covered Accident or Sickness;
- [(9) Mental Illness;]
- [(10) an Accident or Sickness for which You receive benefits under Workers Compensation or similar coverage or for which You would receive benefits under Workers Compensation if the employer had enrolled You for such coverage and You and Your employer had cooperated in filing a claim under that coverage;]
- [(11) Your being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a Physician;] or
- [(12)] intentionally self-inflicted injury or suicide attempt while sane or insane.

[No benefits are payable during any period in which You are incarcerated [or under house arrest].]

[The suspension, revocation or surrender of a professional or occupational license or certificate does not constitute a disability.]

TERMINATION OF INSURANCE

Your coverage will end on the earliest of:

- (1) the date You do not qualify as an Insured;
- (2) the date You retire;
- (3) the date You cease to be on Active Service as defined in Definitions [, except as provided for under the Leave of Absence provision in this Section];
- (4) the end of the last period for which premium has been paid; or
- (5) the date the Policy is discontinued.

If:

- (1) Your coverage ends as a result of Your termination of Active Service;
- (2) such termination is caused by an Accident or Sickness for which Disability Benefits would be payable; and
- (3) Total Disability is established prior to the termination of Active Service,

then Disability Benefits will be paid as if such termination had not occurred, and the terms of any Waiver of Premium provision will apply.

We or the Policyholder may end the Policy on any date by written notice mailed or delivered. If We end the Policy for a reason other than non-payment of premium, the termination becomes effective on the later of the date stated in the notice or forty-five (45) days after We mail or deliver the written notice of such termination. If any portion of the premium due is not paid, the Policy will terminate in accordance with the Grace Period provision. If the Policyholder ends the Policy, the termination becomes effective on the later of the date stated in the notice or the date We receive the written notice of such termination. If the Policy is ended, We will promptly refund any unearned premium, or the Policyholder will promptly pay any earned premium which has not yet been paid. Any unearned and earned premium will be calculated on a pro-rata basis.

Termination of the Policy will have no affect on payment of Disability Benefits for a Total Disability which begins before the Policy is terminated.

[LEAVE OF ABSENCE

Subject to the continued payment of Premiums due, Your coverage may be continued for up to [one] year(s) during a Leave of Absence approved in writing by Your employer.]

PREMIUM CALCULATION AND PAYMENT

Premiums will be computed in accordance with the rates in effect on the Premium due date. [You and the Policyholder will share the cost of Your coverage.] [The initial premium You are responsible for paying is shown on the Schedule of Benefits.] Your premium will change on the first Policy Anniversary Date on or after the date You enter a new class due to age.

The first premium is due on or before the Effective Date of Your coverage. Premiums after the first are due at the end of the period for which the preceding premium was paid.

The Policyholder is responsible for paying all premiums. However, the premiums may be paid by any other party according to a mutual agreement among the other party, the Policyholder and Us.

Premiums may be paid to:

- (1) Our Home Office; or
- (2) Our authorized agent.

Payment of premium for a period before it is due will not guarantee that the insurance will remain in that effect for that period.

The rates may be changed once the Rate Guarantee Period listed in the Schedule has elapsed after the Effective Date of the Policy or on any Premium due date after that. [If, after three (3) years, the Disability Benefits incurred by Us under the Policy represent less than [50%] of the premiums earned under the Policy over the same time period, We will not change the rate until [five (5)] years after the Effective Date of the Policy.] Any subsequent rate changes will not be made more frequently than once every [six (6) months]. No such change in premium will be made unless [30 days] prior notice is given to the Policyholder.

The rates may change prior to the time frames outlined above, however, for reasons that affect the insured risk, which include:

- (1) a change in benefits;
- (2) a new law or change in any existing law that affects the Policy; or
- (3) a material change in the composition or size of the Insureds covered under the Policy.

GRACE PERIOD

A grace period of thirty-one (31) days will be allowed for each premium payment after the first premium. Coverage will remain in effect during the grace period. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder must still pay all unpaid premium. This includes the premium due for the grace period. No grace period is provided after the Policyholder has given notice of intent to end the Policy.

[WAIVER OF PREMIUM

If You become Totally Disabled due to a covered Accident or Sickness, Your insurance will be continued without payment of premium. Waiver of Premium will begin the next premium due date following the [later, earlier] of:

- (1) Your satisfaction of the Elimination Period; or

(2) **[three (3) months]** of continuous Total Disability,
provided premium has been paid from the beginning of Total Disability to the date Waiver of
Premium begins. Waiver of Premium will continue until the earliest of:

- (1) the end of Your Total Disability; or
- (2) the end of the Maximum Benefit Period.]

GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (1) the Policy;
- (2) the application of the Policyholder;
- (3) the Certificates;
- (4) Your application, if any, attached to the Certificate; and
- (5) all riders, endorsements and amendments.

The terms of the Policy can be changed only by rider, 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: Except in the case of fraud, after two (2) years from the Effective Date of Your coverage, no statements in the application can be used to:

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

NOTICE OF CLAIM: Written notice of claim must be given to Us at the address listed on the first page of this Policy, or to Our designee. Such notice should be made within thirty (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.

CLAIM FORMS: Claim forms should be used for filing proof of loss. They will be sent to You within fifteen (15) days of receipt of notice of claim. If claim forms are not supplied within fifteen (15) days, You may give proof as follows:

- (1) in writing;
- (2) setting forth the nature and extent of the loss; and
- (3) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of loss must be given to Us within 180 days after the loss. Late proof may be accepted if:

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

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 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 is 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: We have the right to have You examined as often as is reasonably necessary while a claim is pending. We will pay for such examination.

RECORDS AUTHORIZATION: In the event of a claim, You may be required to provide Us written, unaltered authorization to obtain medical, financial, vocational, occupational and governmental information required to calculate Disability Benefits payable. You must provide Us with such authorization as often as We require, in order that it remain current. Failure to provide such authorization may delay, suspend or terminate Your benefits.

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

- (1) within sixty (60) days after written proof of loss has been furnished as required; or
- (2) more than three (3) years from the time written proof of loss is required to be furnished.

CERTIFICATES: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

- (1) the benefits under the Policy;
- (2) to whom benefits will be paid; and
- (3) 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.

If there is a conflict between the Policy and the Certificate, the Policy will control.

MISSTATEMENT OF AGE: If Your age has been misstated, Your true age will be used to determine all amounts to be paid for loss incurred by You.

INCONTESTABILITY:

All statements made by You are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to You. In the event of Your death or incapacity, Your applicable representative shall be given a copy.

After two years from Your Effective Date of coverage, or from the Effective Date of

increased benefits, no such statement will cause the coverage or the increased benefits to be contested except for fraud.

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.

REIMBURSEMENT OF OVERPAYMENT: The benefits payable under this Policy will be adjusted by other sources of income listed in the Limitations Section. If any income from a source stated in the Limitations Section is received or granted retroactively, You will be responsible for reimbursing Us for any resulting overpayment. You will also be responsible for reimbursing Us for any overpayment resulting from fraud or an error in claim processing made by You, Us or the plan administrator. Reimbursement will be only to the extent of the overpayment involved, and such reimbursement will be required in one lump sum payment at the time You receive the award.

IMPORTANT NOTICE: For questions regarding this Policy, please contact Us at the administrative office listed on first page of this Policy. We may also be contacted by telephone at [1-866-623-2953].

If discussions with Us have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494

<Beazley Name Logo>

Beazley Insurance Company, Inc.
Administrative Office
[Address here]

APPLICATION FOR GROUP INSURANCE

Please check the insurance coverage:

- Disability Income Insurance
- Critical Illness Insurance

A. GENERAL INFORMATION

Full Legal Name of [EMPLOYER, ASSOCIATION]:	Federal Tax ID #:
Street Address: _____ City: _____	County: _____ State: _____ Zip code: _____
Form of Organization: <input type="checkbox"/> Corporation <input type="checkbox"/> Association <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership	List of all Subsidiaries to be included:
Effective Date of Insurance: Month: _____ Date: _____ Year: _____ <i>The effective date of the insurance is subject to approval of this application by Beazley Insurance Company, Inc.</i>	

B. TYPE OF INSURANCE ELECTED

INSURANCE COVERAGE	YES	NO	# ELIGIBLE [EMPLOYEES]	[EMPLOYEE] CONTRIBUTION	BENEFIT SELECTIONS
Short Term Disability (Weekly Benefit)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	<input type="checkbox"/> Mental Illness Limited Benefit <input type="checkbox"/> Partial Disability Benefit <input type="checkbox"/> Residual Disability Benefit <input type="checkbox"/> Rehabilitation Program Services <input type="checkbox"/> Survivor Benefit <input type="checkbox"/> Disability occurring outside the United States or Territories of the United States <input type="checkbox"/> Portability <input type="checkbox"/> FICA Match Benefit
Short Duration Disability (Monthly Benefit)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	
Critical Illness:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____ %	

C. ADDITIONAL INFORMATION

1. Deposit submitted with application [_____]. If the policy is issued, the deposit will apply towards the first month's premium
2. Will all or part of this policy replace similar coverage? Yes No
If yes, list Carrier(s), Policy Number(s), and Termination Date(s): _____.

D. AGREEMENT

The [Employer] and Beazley Insurance Company, Inc. ("We", "Us" or "Our") agree that:

THE APPLICATION should form the basis for and become part of any policy issued. PREMIUM RATES shall: (1) be subject to all provisions in that policy; and (2) be binding on both [Employer] and Us. LIABILITY OF THE COMPANY – We will have no liability until this request has been approved at Our Administrative Office. AUTHORITY OF AGENTS – No agent can change the terms of this request or any policy We issue. No agent can waive any of Our rights or requirements or extend the time for any premium payments. CHANGES AND CORRECTIONS – The acceptance of any policy issued on this request shall constitute ratification of any correction or amendment made by Us. Changes are an amendment to and form a part of the original request and any policy issued.

Please continue to read below for special notices required by state law.

[Employer] (full legal name): _____

Dated at _____ this _____ day of _____, _____.

Signature of Authorized person:	Print Name:	Print Title:
Signature of Licensed Resident Agent:	Print Name of Agent and License Number:	P.O. Box Address (including zip code)

FRAUD WARNING

[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.]

[Arkansas, Louisiana, West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.]

[District of Columbia – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

[Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.]

[Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.]

[Maryland, Oregon – Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[New Jersey - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[New Mexico - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Ohio – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[Oklahoma – 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 is guilty of a felony.]

[Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

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

[Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

<Beazley Name Logo>

POLICYHOLDER NAME:	[XYZ Company, Inc.]		
POLICYHOLDER ADDRESS:	[123 Main Street Small Town, FL 33321]		
INSURER NAME:	Beazley Insurance Company, Inc.		
INSURER ADDRESS: ADMINISTRATIVE OFFICE	[30 Batterson Park Road Farmington, CT 06032]		
INSURER ADDRESS: NOTICE OF CLAIM	[30 Batterson Park Road Farmington, CT 06032]		
POLICY NUMBER:	[1234567]	EFFECTIVE DATE:	[January 1, 2011]
DATE OF ISSUE:	[January 30, 2011]	ANNIVERSARY DATE:	[January 1]

In consideration of the Policyholder's application and the timely payment of premiums, Beazley Insurance Company, Inc. (herein called the Company) agrees to pay the benefits of this Policy, subject to all of its terms and conditions.

This Policy is executed by Beazley Insurance Company, Inc. as of its Date of Issue. This Policy will take effect on the effective date shown above, 12:01 a.m. Standard Time at the address of the Policyholder.

[
Secretary
]

[
President
]

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.

[The coverage under this Policy contains an exclusion for pre-existing conditions. Read your Policy carefully.]

This Policy [does] [does not] cover disabilities due to an occupational Accident or Sickness.

IMPORTANT CANCELLATION INFORMATION – Please read the provision entitled Termination of Insurance

This Policy is a contract between the Policyholder and the Company.

READ YOUR POLICY CAREFULLY

TABLE OF CONTENTS

Schedule of Benefits 3

Definitions 4

Eligibility and Effective Date..... [8]

Disability Benefits..... [10]

Limitations [15]

Exclusions [17]

Termination of Insurance [18]

Premium Calculation and Payment..... [19]

General Provisions..... [21]

SCHEDULE OF BENEFITS

[PLAN: [1]]

ELIGIBILITY: [ALL [PERMANENT] [MEMBERS] [AND] [EMPLOYEES], BETWEEN THE AGES OF 18 AND 64, WORKING [25] HOURS OR MORE PER WEEK AND ON ACTIVE SERVICE.]

MAXIMUM DISABILITY BENEFIT:[\$10,000.00] [Monthly]

MAXIMUM COVERED PERCENT OF COMPENSATION: [80%]

MINIMUM DISABILITY BENEFIT:[\$300.00] [Monthly]

MAXIMUM BENEFIT PERIOD: [60] [Months]

[MAXIMUM MENTAL ILLNESS PERIOD: [24] [Months]]

[MAXIMUM PARTIAL DISABILITY BENEFIT PERIOD: [24] [Months]]

[SURVIVOR BENEFIT [3] [Months]]

ELIMINATION PERIOD:

ACCIDENT: [30 days]

SICKNESS: [30 days]

WAITING PERIOD: [30 days]

[PRE-EXISTING CONDITION PERIOD: [3 Months]]

RECURRENT DISABILITY PERIOD: [3 Months]

RATE GUARANTEE PERIOD: [3 Years]

[MAXIMUM PORTABILITY PERIOD: [24 Months]]

DEFINITIONS

ACCIDENT (or Accidental Injury) means an injury the Insured sustains:

- (1) that is independent of any Sickness;
- (2) over which the Insured has no control;
- (3) that takes place while the Insured's coverage is in force; and
- (4) that is a direct cause of a disability.

If the period of disability begins more than 60 days after an Accident, the disability will be considered to have been caused by a Sickness.

ACTIVE SERVICE means that the Insured is:

- (1) performing in the usual manner, all of the Material and Substantial Duties of his or her Own Occupation for the regularly scheduled number of hours on a scheduled work day; and
- (2) the Material and Substantial Duties are being performed at one of the places of business where the Insured normally performs such duties or at some location to which the Insured's employment sends him or her.

The Insured will be said to be on Active Service on a day that is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of the Insured's 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 BENEFIT means the benefit amount, prior to the application of Limitations, for which the Insured is eligible and for which premium has been paid.

EARNED INCOME means the Insured's gross earnings from his or her personal participation in any occupation(s), profession(s) or business(es). If the Insured's Own Occupation involves ownership of any portion of any profession(s) or business(es), including any corporation, Earned Income includes his or her share of the earnings of such profession(s) or business(es) reduced by any amount that is deductible as a business expense for federal income tax purposes. Earned income does not include investment income, deferred compensation or retirement income.

EFFECTIVE DATE means the date described in the Policy. The date shown in the Insured's individual Certificate will be the 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, as listed in the Schedule, that starts after the Insured's Effective Date of coverage, during which:

- (1) the Insured is Totally Disabled; and
- (2) no Disability Benefits are payable.

GAINFUL EMPLOYMENT means the Insured's Own Occupation, as well as any other occupation or professions for which the Insured is reasonably fitted by education, training or experience.

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

MATERIAL AND SUBSTANTIAL DUTIES means the duties that:

- (1) are normally required for the performance of the Insured's Own Occupation; and
- (2) cannot be reasonably omitted or modified.

MENTAL ILLNESS means psychiatric or psychological conditions, regardless of cause, including but not limited to:

- (1) schizophrenia;
- (2) depression;
- (3) manic depressive or bipolar illness;
- (4) anxiety;
- (5) personality disorders; and/or
- (6) 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;

that are a direct cause of a disability.

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

- (1) stroke;
- (2) trauma;
- (3) viral infection;
- (4) Alzheimer's disease; or

other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

OWN OCCUPATION means all occupations or professions in which the Insured is regularly engaged for wage or profit at the time he or she becomes disabled. An occupation or profession will be defined as it is normally performed in the national economy instead of how the

work tasks are performed for a specific employer or at a specific location.

PHYSICIAN means a practitioner of the healing arts who:

- (1) is practicing within the scope of his or her license in the state where so licensed; and
- (2) is not related to the Insured.

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

POLICYHOLDER means the association, employer or other organization who holds the Policy, as listed on the first page of this Policy.

[PRE-DISABILITY MONTHLY COMPENSATION means:

- (1) if the Insured is a salaried employee, the Insured's Earned Income for the month preceding the month in which the Insured's Total Disability began; otherwise
- (2) if the Insured's Earned Income fluctuates from month to month because of commissioned sales, tips, overtime pay or bonus earnings, the greater of:
 - (a) one twelfth ($1/12^{\text{th}}$) of the Earned Income for the 12 months preceding the month in which the Insured's Total Disability began; or
 - (b) one twenty-fourth ($1/24^{\text{th}}$) of the Earned Income for the 24 months preceding the month in which the Insured's Total Disability began.]

[PRE-DISABILITY WEEKLY COMPENSATION means:

- (1) if the Insured is a salaried employee, the Insured's Earned Income for the week preceding the week in which the Insured's Total Disability began; otherwise
- (2) if the Insured's Earned Income fluctuates from week to week because of commissioned sales, tips, overtime pay or bonus earnings, the greater of:
 - (a) one fifty-second ($1/52^{\text{nd}}$) of the Earned Income for the 52 weeks preceding the week in which the Insured's Total Disability began; or
 - (b) one one-hundred-fourth ($1/104^{\text{th}}$) of the Earned Income for the 104 week preceding the week in which the Insured's Total Disability began.]

PRE-EXISTING CONDITION means an Accident or Sickness for which the Insured has:

- (a) had treatment;
- (b) incurred expense;
- (c) taken medication; or
- (d) received a diagnosis or advice from a Physician,

during the Pre-Existing Condition Period indicated in the Schedule of Benefits, immediately before the Effective Date of coverage. The term Pre-Existing Condition will also include

conditions that are related to such Accident or Sickness.

RECURRENT DISABILITY means a disability caused by an Accident or Sickness which is the same as, or related to, the cause of a prior disability for which Disability Benefits were payable under the Policy.

REGULAR CARE AND ATTENDANCE means attended by a Physician at least once a month or until the Physician determines the Insured:

- (1) has reached his or her maximum point of recovery; and
- (2) is still Totally Disabled, as defined in Definitions.

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

SICKNESS means illness or disease that starts while the Insured's coverage is in force and is the direct cause of a disability. Sickness includes pregnancy and any complications of pregnancy, including but not limited to a non-elective cesarean section.

TOTAL DISABILITY (or Totally Disabled) means that, as the result of a covered Accident or Sickness, the Insured:

- (1) is unable to perform the Material and Substantial Duties of his or her Own Occupation; and
- (2) is under the Regular Care and Attendance of a Physician, whose area of practice is appropriate for the treatment of the Accident or Sickness causing the Insured's disability, based on prevailing medical standards; and
- (3) is not working in Gainful Employment.

WAITING PERIOD means the period of time an Insured must be in Active Service as an employee of the Policyholder, member of the Policyholder, or employee of a member of the Policyholder, before he or she becomes eligible to enroll for coverage under this Policy.

ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who:

- (1) are in Active Service as
 - [(a) employees of the Policyholder][,]
 - [(b) members of the Policyholder][,]
 - [(c) employees of a member of the Policyholder] [or]
 - [(d) employees of an employer who is obligated to employ persons who are members of the Policyholder];
- (2) qualify as eligible Insureds as defined in the Policyholder's application; and
- (3) 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.

This Policy will allow from time to time, that new eligible Insureds of the Policyholder be added to the eligible classes of Insureds originally insured under the Policy.

EFFECTIVE DATE

The Insured's coverage will take effect on the Effective Date of the Policy if he or she:

- (1) applies in writing on or before said Effective Date;
- (2) meets the Company's underwriting rules; and
- (3) is on Active Service, as defined in Definitions.

subject to the payment of all premiums due.

After the Effective Date of the Policy, the Insured's insurance will take effect on the later of the requested Effective Date or the date the Company approves the written application (subject to the Company's underwriting rules), if the Insured is on Active Service, has met the Waiting Period shown in the Schedule, and premium has been paid.

Employees/members who want to apply for this insurance must apply for coverage that will provide benefits according to the applicable class set out in the Policyholder's application.

[[If the Insured is not on Active Service, due to an Accident or Sickness when his or her coverage would otherwise take effect, it will take effect on the next premium due date after the date the Insured returns to Active Service. If the Insured is not on Active Service when his or her coverage would otherwise take effect, coverage will take effect on the first day of the calendar month after the date the Insured returns to Active Service, provided that the Insured returns to Active Service within 30 days of the proposed Effective Date. If the absence from Active Service extends beyond 30 calendar days, the Insured must complete a new application for coverage.]

[If the Insured is not on Active Service due to:

- (1) an Accident or Sickness; or
- (2) non-employment by reason of layoff, strike or termination of employment with the

Insured's last employer,

when his or her coverage would otherwise take effect, coverage will take effect on the next premium due date after the date the Insured's return to Active Service, if the Insured returns to Active Service within 30 days of the proposed effective date. If the absence from Active Service extends beyond 30 calendar days, the Insured must complete a new application for coverage.]]

A change in the amount of benefits will take effect on the first day of the next month following written notice to the Company if:

- (1) such change is approved by the Company; and
- (2) the Insured is on Active Service on the date such change is to take effect

subject to the payment of all premiums due.

[However, no increase shall take effect if the Insured is not on Active Service due to non-employment by reason of layoff, strike or termination of employment with the Insured's last employer.]

Any change in the Policy will apply only to new periods of disability that begin after such date, subject to all the provisions of the Policy.

DISABILITY BENEFITS

Disability Benefits will be paid for only one disability when:

- (1) more than one disability exists at the same time; or
- (2) a disability results from two or more causes.

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

[The Company will not pay a benefit for more than one of the following at the same time: Total Disability[,] [and] [Partial Disability] [and] [Residual Disability].]

If the Maximum Benefit Period stated in the Schedule is more than one year in length, the Maximum Benefit Period will be adjusted based on the Insured's age as of the date benefits begin, as follows:

- (1) Subtract the Maximum Benefit Period (number of years) from 70 years, then:
 - (a) If the Insured is younger than this age, benefits will be payable for up to the number of years stated as the Maximum Benefit Period.
 - (b) If the Insured is older than this age, but younger than age 69, benefits will be payable until the Insured attains age 70.
 - (c) If the Insured is age 69 or older, benefits will be payable for up to one year.
- (2) The premium and benefit amount will not change due to a change in the Maximum Benefit Period.

TOTAL DISABILITY BENEFIT

A Total Disability Benefit will be paid if the Insured becomes Totally Disabled, while his or her coverage is in force, for the period of Total Disability that continues beyond the Elimination Period.

No such benefits will be paid beyond the Maximum Benefit Period stated in the Schedule.

The Elimination Period and Maximum Benefit Period apply separately to each period of Total Disability.

[MENTAL ILLNESS LIMITED BENEFIT

If the Insured is Totally Disabled due to a Mental Illness, Disability Benefits will be paid for the period of Total Disability up to the Maximum Mental Illness Benefit Period shown in the Schedule.]

RECURRENT DISABILITY

A Recurrent Disability will be considered part of the prior disability unless separated by the Insured's return to Active Service for at least the Recurrent Disability Period stated in the Schedule of Benefits.

A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability that begins after termination of coverage will not be considered a Recurrent Disability and will not be covered under the Policy.

[PARTIAL DISABILITY BENEFIT

A Partial Disability Benefit of up to 50% of the Total Disability Benefit will be paid if the Insured becomes Partially Disabled following a period of Total Disability. However, the sum of the Partial Disability Benefit, the Insured's [monthly] Earned Income while receiving Partial Disability Benefits, and [monthly] income from all other sources listed in Limitations Section may not exceed 80% of the Insured's [Pre-Disability Monthly Compensation]. [In this event, the Minimum Disability Benefit, if any, stated on the Schedule will not be payable.]

Partial Disability Benefits will be payable beginning the first day following the date Total Disability ends. The Partial Disability Benefit will be payable for the period of Partial Disability up to the Maximum Partial Disability Benefit Period shown in the Schedule. However, the combined period of time for which benefits are payable for Total Disability and Partial Disability may not exceed the Maximum Benefit Period stated in the Schedule.

Payment of the Partial Disability Benefit is subject to the following conditions:

- (1) The Elimination Period for Total Disability must be satisfied and Total Disability Benefits payable.
- (2) The Partial Disability must be the result of the same Accident or Sickness which caused Total Disability.

PARTIAL DISABILITY (or Partially Disabled) means that, as the result of a covered Accident or Sickness:

- (1) the Insured is unable to perform one or more of the Material and Substantial Duties of his or her Own Occupation, or is able to perform all of the Material and Substantial Duties of his or her Own Occupation for no more than 80% of his or her regularly scheduled number of hours;
- (2) the Insured is not working in his or her Own Occupation;
- (3) the Insured is employed in another occupation; and
- (4) the Insured's [monthly] Earned Income is less than 80% of his or her [Pre-Disability Monthly Compensation].]

[RESIDUAL DISABILITY BENEFIT

A Residual Disability Benefit will be paid if the Insured becomes Residually Disabled following a period of Total Disability. The Residual Disability Benefit will be equal to:

- (1) The Total Disability Benefit, if the sum of the Insured's [monthly] Earned Income while Residually Disabled and [monthly] income from all other sources listed in Limitations Section is less than 20% of the Insured's [Pre-Disability Monthly Compensation];
- (2) Zero, if the sum of the Insured's [monthly] Earned Income while Residually Disabled and [monthly] income from all other sources listed in Limitations Section is more than 80% of the Insured's [Pre-Disability Monthly Compensation];

otherwise,

-
- (3) The Total Disability Benefit multiplied by the Residual Disability Income Replacement Percentage.

Residual Disability Benefits will be payable beginning the first day following the date Total Disability ends. The combined period of time for which benefits are payable for Total Disability and Residual Disability may not exceed the Maximum Benefit Period stated in the Schedule.

Payment of the Residual Disability Benefit is subject to the following conditions:

- (1) The Elimination Period for Total Disability must be satisfied and Total Disability Benefits payable.
- (3) The Residual Disability must be the result of the same Accident or Sickness which caused Total Disability and for which Total Disability Benefits were payable.

RESIDUAL DISABILITY (or Residually Disabled) means that, as the result of a covered Accident or Sickness:

- (1) the Insured is unable to perform one or more of the Material and Substantial Duties of his or her Own Occupation, or is able to perform all of the Material and Substantial Duties of his or her Own Occupation for no more than 80% of his or her regularly scheduled number of hours;
- (2) the Insured is working in his or her Own Occupation; and
- (3) the Insured's [monthly] Earned Income is less than 80% of his or her [Pre-Disability Monthly Compensation].

RESIDUAL DISABILITY INCOME REPLACEMENT PERCENTAGE means 100% minus the ratio of the sum of the Insured's [monthly] Earned Income and [monthly] income from all other sources listed in Limitations Section, while Residually Disabled, to the Insured's [Pre-Disability Monthly Compensation].]

[REHABILITATION PROGRAM SERVICES

The Company may offer, to an Insured receiving Disability Benefits, participation in a Rehabilitation Program to assist him or her to return to Gainful Employment. [The Company has the right to suspend Disability Benefits if the Insured does not participate in the Rehabilitation Program that is offered.]

The Rehabilitation Program will start when a written Rehabilitation Agreement is signed by:

- (1) the Insured;
- (2) the Company; and
- (3) the Policyholder, if necessary.

The Rehabilitation Program may include, but is not limited to, the following services:

- (1) vocational assessment of the Insured's work potential;
- (2) treatment programs such as support groups, physical therapy, occupational therapy, and speech therapy
- (3) coordination and transition planning with an employer for the Insured's return to Gainful Employment;
- (4) consulting with the Insured's Physician on his or her return to Gainful Employment and need for accommodations or worksite modifications;

-
- (5) training in job seeking skills and resume preparation;
 - (6) retraining; and
 - (7) assistance with relocation services.

The Company will determine which Insureds are eligible for the Rehabilitation Program and amount and nature of services provided under the Rehabilitation Program. The Company will pay for all services provided under the Rehabilitation Program.]

[SURVIVOR BENEFIT

If the Insured:

- (1) dies while receiving Disability Benefits; and
- (2) has been Totally Disabled for at least [180 consecutive days], a Survivor Benefit will be paid to the Insured's beneficiary or estate.

The Survivor Benefit will be paid in a lump sum and will be equal to Disability Benefit that would be payable over the period listed in the Schedule as the Survivor Benefit.]

[DISABILITIES OCCURRING OUTSIDE THE UNITED STATES OR TERRITORIES OF THE UNITED STATES:

If the Insured becomes Totally Disabled outside the United States or territories of the United States, Disability Benefits due to the Insured will be limited to the lesser of:

- (1) [2 Months]; or
- (2) the Maximum Benefit Period specified in the Schedule of Benefits.

To continue to receive any additional Benefit Payments due Insured, he or she must reside in the United States or a territory of the United States for the duration of the period of Total Disability.]

[PORTABILITY

This Policy provides portability for up to the Maximum Portability Period listed in the Schedule, when an Insured's coverage under the Policy terminates because his or her [employment] [or] [membership] with the Policyholder ends; provided:

- (1) the Insured is not disabled, retired or on a leave of absence; and
- (2) the Insured was covered under the Policy [, for at least 12 months in a row,] at the date [employment] [or] [membership] ended. [The 12 months may be a combination of coverage under this Policy, and under any prior group short term disability policy this Policy replaces.]

Portability is not available to an Insured whose coverage terminates because the Policy is terminated by the Policyholder or the Company.

To continue coverage under the Portability provision, written application and the first premium payment must be made within 31 days of the date insurance ends under this Policy.

The coverage continued under the Portability provision is the coverage in effect on the date the Insured's [employment] [or] [membership] ends, including the Disability Benefit, Maximum

Benefit Period and Elimination Period. [Continued coverage may not be increased. The Insured may request decreased continued coverage at any time during the continuation period by completing a request form supplied by the Company.]

Coverage under the Portability provision will cease on the earliest of:

- [(1) the date the Policy terminates;]
- (2) the end of the last period for which premium has been paid;
- (3) the date coverage under this Portability provision has been continued for the Maximum Portability Period listed in the Schedule;
- (4) the date the Insured retires or dies; and
- (5) the date the Insured is covered under any other group short term disability plan.

Premiums for continued coverage under the Portability provision shall be derived solely from the Insured's contribution. For Portability coverage to become effective and remain in effect, each Insured shall make premium payment for his or her continued coverage directly to the Company, on or before each premium due date. The Company will send each Insured a billing statement in advance of each premium due date. The Insured is responsible for paying all premiums as they become due.

The required premium for the continued coverage will equal the premium in effect when the Insured's employment ended [plus a direct billing fee based on premium frequency].]

[FICA MATCH BENEFIT

With respect to any Disability Benefits paid under this Policy, the Company will pay the amount of associated FICA tax due and payable to the appropriate government agency.

The FICA Match Benefit will end upon the earliest of the following:

- (1) the date the Policy terminates;
- (2) the date Disability Benefits end; or
- (3) the effective date of the termination of the FICA Match Benefit, initiated by either the Policyholder or the Company, via written notice mailed or delivered, subject to the following:
 - (a) If the Company initiates, the termination of the FICA Match Benefit becomes effective on the later of the date stated in the notice or forty-five (45) days after the Company mails or delivers the written notice.
 - (b) If the Policyholder initiates, the termination of the FICA Match Benefit becomes effective on the later of the date stated in the notice or the date the Company receives the written notice.

Termination of the FICA Match Benefit will have no effect on payment of FICA Match Benefits for a Total Disability which begins before the FICA Match Benefit is terminated.

The entire amount of Premium for the FICA Match Benefit is to be provided by the Policyholder's funds. No premium contribution is due or may be collected from any Insured under the Policy for the FICA Match Benefit.]

LIMITATIONS

OTHER INCOME

The Disability Benefits paid to the Insured will be reduced by the payments the Insured is entitled to receive from:

- (1) group insurance coverage or like coverage for persons in a group;
- (2) Federal Social Security Act (this includes benefits paid to the Insured and his or her dependents on account of the Insured's disability);
- (3) Federal Old Age Benefits under the Federal Social Security Act on the Insured's own behalf;
- [(4) salary or wage continuance plans such as accrued sick leave or paid personal time used as sick leave, paid for by the Policyholder or the Insured's employer which extend beyond the Elimination Period stated in the Schedule;]
- [(5) Governmental or other retirement system as a result of the Insured's employment, whether due to disability, normal retirement or voluntary election of retirement benefits;]
- [(6) Workers Compensation, Employers' Liability or similar law;]
- [(7) a State disability plan;] and
- [(8)] pension plan to which the Policyholder or the Insured's employer contributes or makes payroll deductions.

If it appears that the Insured is entitled to any of the above income sources (this includes benefits payable to the Insured and to his or her dependents), unless the Insured shows proof to the Company that payments under these applicable programs or acts have been applied for, but will not be paid, the Company:

- (1) will assume the Insured is receiving such payments; and
- (2) may require the Insured to reapply (but not more frequently than annually) once a denial of benefits has been received from any of the above sources, and appeals have been pursued. Failure to reapply for benefits when required by the Company will result in the Company's estimation of payment by those sources.

Benefits will not be reduced due to a cost of living increase in Social Security if the increase takes place while benefits are payable under the Policy.

With respect to any and all of the above sources, if lump sum payment is received by the Insured or his or her dependents for a period previously paid by the Company, any resulting overpayment by the Company will be due the Company on a lump sum basis.

If the Insured has the option of taking retirement benefits on a monthly basis, but choose to receive retirement benefits on a lump sum basis, the Company may assume the Insured is receiving retirement benefits based upon the lowest monthly retirement plan benefit available to the Insured prior to lump sum withdrawal.

Unless stated otherwise, the Disability Benefit payable will be no less than the Minimum Disability Benefit amount set out in the Schedule.

[PRE-EXISTING CONDITION LIMITATION

There will be no Disability Benefit payable for a Total Disability caused or contributed to by, or resulting from a Pre-Existing Condition during the first 12 months of coverage.

[If the Insured was covered under the prior carrier's group disability policy at the date of change in coverage to a group disability policy provided by the Company, and was not subject to a Pre-Existing Condition limitation under the prior carrier's policy, there shall be no Pre-Existing Condition limitation under the Company's policy. However, if the Insured was subject to a Pre-Existing Condition limitation under the prior carrier's policy, credit will be given toward satisfaction of the Pre-Existing Condition limitation of the Company's policy for that period of time that the Insured was continuously covered under the prior carrier's policy.]

[Any increase in the amount of the Insured's Disability Benefit [which exceeds an annual increase of \$200.00] will be subject to this Pre-Existing Condition Limitation, beginning on the Effective Date of the increase.]]

EXCLUSIONS

The Policy does not provide benefits for any disability that results from:

- (1) an act of war, declared or undeclared;
- (2) active participation in a riot, civil commotion, civil disobedience or unlawful assembly;
- (3) Accident sustained or Sickness contracted while in the service of the armed forces of any country;
- (4) committing a felony;
- (5) air travel, except as a fare-paying passenger on a commercial airline;
- (6) taking part in a contest of speed, parachuting or hang gliding;
- (7) participation in a sport for compensation or profit;
- (8) elective surgery (with the exception of organ donation) or cosmetic surgery, unless due to a covered Accident or Sickness;
- [(9) Mental Illness;]
- [(10) an Accident or Sickness for which the Insured receives benefits under Workers Compensation or similar coverage or for which the Insured would receive benefits under Workers Compensation if the employer had enrolled the Insured for such coverage and the Insured and employer had cooperated in filing a claim under that coverage;]
- [(11) the Insured being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a Physician;] or
- [(12)] intentionally self-inflicted injury or suicide attempt while sane or insane.

[No benefits are payable during any period in which the Insured is incarcerated [or under house arrest].]

[The suspension, revocation or surrender of a professional or occupational license or certificate does not constitute a disability.]

TERMINATION OF INSURANCE

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

- (1) the date the Insured does not qualify as an Insured;
- (2) the date the Insured retires;
- (3) the date the Insured ceases to be on Active Service as defined in Definitions [, except as provided for under the Leave of Absence provision in this Section];
- (4) the end of the last period for which premium has been paid; or
- (5) the date the Policy is discontinued.

If:

- (1) the Insured's coverage ends as a result of his or her termination of Active Service;
- (2) such termination is caused by an Accident or Sickness for which Disability Benefits would be payable; and
- (3) Total Disability is established prior to the termination of Active Service,

then Disability Benefits will be paid as if such termination had not occurred, and the terms of any Waiver of Premium provision will apply.

The Company or the Policyholder may end the Policy on any date by written notice mailed or delivered. If the Company ends the Policy for a reason other than non-payment of premium, the termination becomes effective on the later of the date stated in the notice or forty-five (45) days after the Company mails or delivers the written notice of such termination. If any portion of the premium due is not paid, the Policy will terminate in accordance with the Grace Period provision. If the Policyholder ends the Policy, the termination becomes effective on the later of the date stated in the notice or the date the Company receives the written notice of such termination. If the Policy is ended, the Company will promptly refund any unearned premium, or the Policyholder will promptly pay any earned premium which has not yet been paid. Any unearned and earned premium will be calculated on a pro-rata basis.

Termination of the Policy will have no affect on payment of Disability Benefits for a Total Disability which begins before the Policy is terminated.

[LEAVE OF ABSENCE

Subject to the continued payment of Premiums due, the Insured's coverage may be continued for up to [one] year(s) during a Leave of Absence approved in writing by the Insured's employer.]

PREMIUM CALCULATION AND PAYMENT

Premiums will be computed in accordance with the rates in effect on the Premium due date. [The portion of the Insured's premium that he or she is responsible for contributing is shown on the Insured's Certificate Schedule of Benefits.] An Insured's premium will change on the first Policy Anniversary Date on or after the date the Insured enters a new class due to age. The total premium for the Policy is the sum of premiums for all Insureds.

The first premium is due on or before the Effective Date of the Insured's coverage. Premiums after the first are due at the end of the period for which the preceding premium was paid.

The Policyholder is responsible for paying all premiums. However, the premiums may be paid by any other party according to a mutual agreement among the other party, the Policyholder and the Company.

Premiums may be paid to:

- (1) the Company's Home Office; or
- (2) the Company's authorized agent.

Payment of premium for a period before it is due will not guarantee that the insurance will remain in that effect for that period.

The rates may be changed once the Rate Guarantee Period listed in the Schedule has elapsed after the Effective Date of the Policy or on any Premium due date after that. [If, after three (3) years, the Disability Benefits incurred by the Company under the Policy represent less than [50%] of the premiums earned under the Policy over the same time period, the Company will not change the rate until [five (5)] years after the Effective Date of the Policy.] Any subsequent rate changes will not be made more frequently than once every [six (6) months]. No such change in premium will be made unless [30 days] prior notice is given to the Policyholder.

The rates may change prior to the time frames outlined above, however, for reasons that affect the insured risk, which include:

- (1) a change in benefits;
- (2) a new law or change in any existing law that affects the Policy; or
- (3) a material change in the composition or size of the Insureds covered under the Policy.

GRACE PERIOD

A grace period of thirty-one (31) days will be allowed for each premium payment after the first premium. Coverage will remain in effect during the grace period. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder must still pay all unpaid premium. This includes the premium due for the grace period. No grace period is provided after the Policyholder has given notice of intent to end the Policy.

[WAIVER OF PREMIUM

If the Insured becomes Totally Disabled due to a covered Accident or Sickness, his or her insurance will be continued without payment of premium. Waiver of Premium will begin the next premium due date following the [later, earlier] of:

(1) the Insured's satisfaction of the Elimination Period; or

(2) **[three (3) months]** of continuous Total Disability,

provided premium has been paid from the beginning of Total Disability to the date Waiver of Premium begins. Waiver of Premium will continue until the earliest of:

(1) the end of the Insured's Total Disability; or

(2) the end of the Maximum Benefit Period.]

GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (1) the Policy;
- (2) the application of the Policyholder;
- (3) the Certificates;
- (4) the Insured's application, if any, attached to the Certificate; and
- (5) all riders, endorsements and amendments.

The terms of the Policy can be changed only by rider, 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: Except in the case of fraud, after two (2) years from the Effective Date of the Insured's coverage, no statements in the application can be used to:

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

NOTICE OF CLAIM: Written notice of claim must be given to the Company at the address listed on the first page of this Policy, or to the Company's designee. Such notice should be made within thirty (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.

CLAIM FORMS: Claim forms should be used for filing proof of loss. They will be sent to the Insured within fifteen (15) days of receipt of notice of claim. If claim forms are not supplied within fifteen (15) days, the Insured can give proof as follows:

- (1) in writing;
- (2) setting forth the nature and extent of the loss; and
- (3) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of loss must be given to the Company within 180 days after the loss. Late proof may be accepted if:

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

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 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 he or she 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 is 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: The Company has the right to have the Insured examined as often as is reasonably necessary while a claim is pending. The Company will pay for such examination.

RECORDS AUTHORIZATION: In the event of a claim, an Insured may be required to provide the Company written, unaltered authorization to obtain medical, financial, vocational, occupational and governmental information required to calculate Disability Benefits payable. The Insured must provide us with such authorization as often as The Company requires, in order that it remain current. Failure to provide such authorization may delay, suspend or terminate the Insured's benefits.

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

- (1) within sixty (60) days after written proof of loss has been furnished as required; or
- (2) more than three (3) years from the time written proof of loss is required to be furnished.

CERTIFICATES: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

- (1) the benefits under the Policy;
- (2) to whom benefits will be paid; and
- (3) 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.

If there is a conflict between the Policy and the Certificate, the Policy will control.

MISSTATEMENT OF AGE: If the Insured's age has been misstated, the Insured's true age will be used to determine all amounts to be paid for loss incurred by the Insured.

INCONTESTABILITY: All statements made by the Policyholder to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or

to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder. After two years from the Effective Date, no such statement will cause this Policy to be contested except for fraud.

All statements made by an Insured are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the Insured. In the event of an Insured's death or incapacity, his or her applicable representative shall be given a copy.

After two years from a Insured's Effective Date of coverage, or from the Effective Date of increased benefits, no such statement will cause the coverage or the increased benefits to be contested except for fraud.

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.

REIMBURSEMENT OF OVERPAYMENT: The benefits payable under this Policy will be adjusted by other sources of income listed in the Limitations Section. If any income from a source stated in the Limitations Section is received or granted retroactively, the Insured will be responsible for reimbursing the Company for any resulting overpayment. The insured will also be responsible for reimbursing the Company for any overpayment resulting from fraud or an error in claim processing made by the Insured, the Company or the plan administrator. Reimbursement will be only to the extent of the overpayment involved, and such reimbursement will be required in one lump sum payment at the time the Insured receives the award.

IMPORTANT NOTICE: For questions regarding this Policy, please contact the Company at the administrative office listed on first page of this Policy. The Company may also be contacted by telephone at [1-866-623-2953].

If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494

SERFF Tracking Number: PERR-127032459 State: Arkansas
 Filing Company: Beazley Insurance Company, Inc. State Tracking Number: 48032
 Company Tracking Number: BICI-DI-AR-11-01-F
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Group Short Term/Voluntary Short Term Disability Income
 Project Name/Number: BICI-DI-AR-11-01-F/BICI-DI-AR-11-01-F

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/01/2011
Comments:		
Attachment: Beazley DI AR Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/01/2011
Comments: Please refer to Form Schedule tab.		

	Item Status:	Status Date:
Satisfied - Item: Authorization letter	Approved-Closed	03/01/2011
Comments:		
Attachment: DI Filing Authorization Form.pdf		

	Item Status:	Status Date:
Satisfied - Item: Filing Memorandum	Approved-Closed	03/01/2011
Comments:		
Attachment: DI Filing Memo 20110131.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statements of Variability	Approved-Closed	03/01/2011
Comments:		
Attachments:		

SERFF Tracking Number: PERR-127032459 *State:* Arkansas
Filing Company: Beazley Insurance Company, Inc. *State Tracking Number:* 48032
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TOI: H11G Group Health - Disability Income *Sub-TOI:* H11G.002 Short Term
Product Name: Group Short Term/Voluntary Short Term Disability Income
Project Name/Number: BICI-DI-AR-11-01-F/BICI-DI-AR-11-01-F

DI Certificate SOV.pdf
DI Master Policy SOV.pdf

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Beazley Insurance Company, Inc.

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with AR 23-80-206.

Form Number	Score
AHDIA0003 102010 Ed.	57.75
AHDIA0002 102010 Ed.	54.66
AHDIC0001-AR 102010 Ed.	70.30
AHILA0001 102010 Ed.	47.96
AHDIM0001-AR 102010 Ed.	69.22

Signed: Christine Oldridge
(Company officer)

Name: CHRISTINE OLDRIDGE

Title: Secretary

Date: 18 Feb. 2011

November 17, 2010

Beazley Group

7760 France Avenue South
Suite 1100
Bloomington, MN 55435
USA

Phone (952) 886 7221
Fax (952) 886 7501

info@beazley.com
www.beazley.com

To Whom It May Concern:

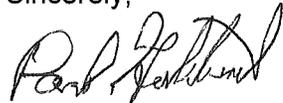
Perr&Knight, Inc. is hereby authorized to submit rate, rule, and form filings on behalf of Beazley Insurance Company, Inc. This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed in be in effect until rescinded in writing.

Please direct all correspondences and inquiries related to this filing to Perr&Knight, Inc. at the following address:

State Filings Department
Perr&Knight, Inc.
881 Alma Real Drive, Suite 205
Pacific Palisades, CA 90272
Tel: (888) 201-5123
Fax: (310) 230-1061
doi@perrknight.com

Please contact me at 952-232-7466 if you have any questions regarding this authorization.

Sincerely,



Paul Gulstrand
Head of Accident & Health Insurance, USA
Email: paul.gulstrand@beazley.com

beazley

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BEAZLEY INSURANCE COMPANY, INC.

**GROUP SHORT TERM/SHORT DURATION
DISABILITY INCOME**

FILING MEMORANDUM

With this filing, Beazley Insurance Company, Inc. is introducing its new Group Short Term/Short Duration Disability Income product. The following forms will be utilized with this product:

- Master Policy
- Certificate of Insurance
- Group Application
- Employee Enrollment Form
- Employee Enrollment Form – Medical History

All of the forms contain bracketed information in order to allow for flexibility in designing customized policies for eligible groups. Statements of Variability, which explain how the bracketing will be utilized, are provided for both the Master Policy and Certificate of Insurance.

The group application and enrollment forms may be presented in written or electronic format. When presented electronically, the actual wording of the statements and questions will not change, but based on responses, they may appear in a slightly different order. Logic will be built into the electronic system to allow only the applicable information and questions to appear to the applicant.

Beazley Insurance Company, Inc.
Disability Income Certificate (AHDIC0001 102010 Ed.)
Statement of Variability

STD = Short Term Disability (Weekly Benefit)
SDD = Short Duration Disability (Monthly Benefit)

Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
1	Policy Face Page	Insurer Address (Administrative Office)	Information may vary based on where policy is serviced.
1		Insurer Address (Notice of Claim)	Information may vary based on where claims are handled.
1		15 Day Right to Examine	This provision may be included based on policyholder specifics.
1		Pre-Existing Condition Notice	This notice will be included if the policy includes a Pre-Existing Condition Exclusion.
1		Occ/Non-Occ Notice	The bracketed portions of this notice will vary depending on whether non-Occupational or 24 Hour coverage is provided.
2	Table of Contents	Page Numbers	Page numbers may change to accommodate modifications due to variability changes.
3	Schedule of Benefits	Insured Name	Information will vary by Insured.
3		Certificate Number	Information will vary by Insured.
3		Certificate Effective Date	Information will vary by Insured.
3		Issue Age	Information will vary by Insured.
3		Policyholder Name	Information will vary by Policyholder.
3		Policyholder Number	Information will vary by Policyholder.
3		Eligibility	The terms, "permanent," "members," "and," and "employees" may be used to reflect policyholder specifics. Only one of the terms may be used, or the terms may be used together. Minimum weekly working hours will be between 10 and 30.
3		Disability Benefit	The disability benefit amount selected by the Insured will be shown here.
3		Minimum Disability Benefit	The minimum disability benefit amount will be shown here. The minimum disability benefit amount will be \$25 per week for STD or \$300 per month for SDD.
3	Maximum Benefit Period	The maximum benefit period will be shown here. The maximum benefit period options for STD are	

Beazley Insurance Company, Inc.
Disability Income Certificate (AHDIC0001 102010 Ed.)
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Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
			13, 26, 52 or 104 weeks. The maximum benefit period options for SDD are 6, 12, or 24 or 60 months.
3		Maximum Mental Illness Period	If the mental illness benefit is subject to a sublimit, the sublimit is listed here. The valid sublimits are 13, 26 or 52 weeks for STD or 6, 12, 24 months for SDD. If mental illness disabilities are excluded or covered with no sublimit this line is deleted in its entirety.
3		Maximum Partial Disability Benefit Period	This entire line may be deleted if Partial Disability benefits are not provided. If provided, the maximum partial disability benefit period will be shown here. Maximum partial disability benefits may be any length of time up to the Maximum Benefit Period.
3		Survivor Benefit	This entire line may be deleted if Survivor Benefits are not provided. If provided, the number of disability payments that will be paid out as a lump sum to survivors is listed here. The valid survivor benefit amounts are 3, 4, 5, 6, 9, and 12 weeks for STD and 1, 2 and 3 months for SDD.
3		Elimination Period	The elimination period will be shown here expressed in days. The accident/sickness elimination period options for STD are: 0/3, 3/3, 0/7, 7/7, 7/14, 14/14, 30/30, 60/60 or 90/90. The accident/sickness elimination period options for SDD are: 30/30, 60/60 or 90/90.
3		Waiting Period	The waiting period may be 30 days or 0 days.
3		Pre-Existing Condition Period	The pre-existing condition period will be shown here. The pre-existing condition period options are 3, 6 or 12 months. If there is no pre-existing condition limitation, this line will be deleted.
3		Recurrent Disability Period	The recurrent disability period will be shown here. The recurrent disability period will vary between 3 and 12 months.
3		Rate Guarantee Period	The bracketed portion of this provision can vary between 1 and 3 years.
3		Maximum Portability Period	This line will be deleted if the Portability option benefit is not provided. If Portability is included, the length of the maximum portability period will be 12 or 24 months.
3		Initial Premium	This line will be deleted if the Policyholder is paying 100% of the premium. The frequency of payment options are variable and include weekly, monthly, quarterly, semi-annually and annually. The premium listed will vary by Insured.
6		Definitions	Pre-Disability Monthly Compensation

Beazley Insurance Company, Inc.
Disability Income Certificate (AHDIC0001 102010 Ed.)
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Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
6		Pre-Disability Weekly Compensation	This definition is included for STD policies that pay a weekly benefit. This definition is excluded for SDD policies that pay a monthly benefit.
8	Eligibility and Effective Date	Eligibility	The bracketed portions of this provision will be included based on policyholder specifics.
8/9		Effective Date	Language contained within brackets may be deleted in its entirety to meet policyholder specifics.
10	Disability Benefits	Introductory paragraph	The bracketed references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits. In addition, for STD policies, 1/30 th will be changed to 1/7 th .
10		Second paragraph	This sentence will be included if partial and/or residual disability benefits are provided.
10		Mental Illness Limited Benefit	If benefits for mental illness are not sublimited, this provision is not needed and will be deleted.
11		Partial Disability Benefit	If partial disabilities are not covered, this provision is not needed and will be deleted. Within the provision, the references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits. Language regarding the minimum disability benefit may be deleted on a policyholder specific basis.
11/12		Residual Disability Benefit	If residual disabilities are not covered, this provision is not needed and will be deleted. The bracketed references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits.
12/13		Rehabilitation Program Services	If Rehabilitation Services are not provided, this provision is not needed and will be deleted. Within the provision, there is a provision that makes participation mandatory. This may or may not be included base on case specifics.
13		Survivor Benefit	If survivor benefits are not provided, this provision is not needed. Within the provision, the number of days the insured must have been receiving benefits prior to death is variable. The valid values are 2 to 180 days depending on case specifics.
13		Disabilities Occurring Outside the United States or Territories of the United States	If benefits paid to Insureds residing outside the U.S. are to be sublimited, this provision is included. The maximum number of benefits can be 1 or 2 months.

Beazley Insurance Company, Inc.
Disability Income Certificate (AHDIC0001 102010 Ed.)
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Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
13/14		Portability	If portability is not being provided as a benefit, this section will be deleted. Reference is made to employment or membership depending on the policy characteristics. Language regarding increasing and decreasing coverage after it is ported may be deleted depending on policyholder specifics. If the ported certificate will be allowed to continue past the termination of the Master Policy, the first reason for termination will be deleted. Language regarding billing fees may be deleted if not applicable for a particular policyholder.
15	Limitations	Other Income	Language contained within brackets may be deleted in its entirety to meet policyholder specifics.
16		Pre-Existing Condition Limitation	If no Pre-Existing condition applies, this entire provision is deleted. Language regarding waiving/modifying or specifically not waiving the pre-existing condition for prior coverage may be deleted on a policyholder specific basis. Language regarding the application of the pre-existing condition limitation on increases in coverage may be deleted on a policyholder specific basis.
17	Exclusions	Exclusions	Exclusions contained within brackets may be deleted in their entirety to meet policyholder specifics. The mental illness exclusion is deleted if mental illness coverage is provided at full or sublimited benefit amounts.
18	Termination of Insurance	Leave of Absence	Entire provision may be deleted to meet policyholder specifics. Leave of Absence period may be for up to 1 or 2 years.
19	Premium Calculation and Payment	Premium Calculation and Payment	If either the Policyholder or Insured is responsible for 100% of the premium, the sentence regarding the sharing of cost will be deleted. If the Policyholder is responsible for 100% of the premium the statement that premium is listed on the Schedule of Benefits will be deleted. Additional rate guarantees for the 4 th and 5 th year may be provided if the loss ratio in the first 3 years is less than or equal to a specified target loss ratio. If the additional rate guarantees are not provided, this language will be deleted. After the initial rate guarantee period, subsequent rate changes may not be implemented more frequently than every 6 months or longer. The number of days notice for changes in premium may vary between 30 and 90 days.
19/20		Waiver of Premium	Entire provision may be deleted to meet case specifics. The bracketed language within the provision will be varied based on policyholder specifics.

Beazley Insurance Company, Inc.
Disability Income Master Policy (AHDIM0001 102010 Ed.)
Statement of Variability

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SDD = Short Duration Disability (Monthly Benefit)

Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability	
1	Policy Face Page	Policyholder Name	Information will vary by Policyholder.	
1		Policyholder Address	Information will vary by Policyholder.	
1		Insurer Address (Administrative Office)	Information may vary based on where policy is serviced.	
1		Insurer Address (Notice of Claim)	Information may vary based on where claims are handled.	
1		Policy Number	Information will vary by Policyholder.	
1		Date of Issue	Information will vary by Policyholder.	
1		Effective Date	Information will vary by Policyholder.	
1		Anniversary Date	Information will vary by Policyholder.	
1		Pre-Existing Condition Notice	This notice will be included if the policy includes a Pre-Existing Condition Exclusion.	
1		Occ/Non-Occ Notice	The bracketed portions of this notice will vary depending on whether non-Occupational or 24 Hour coverage is provided.	
2		Table of Contents	Page Numbers	Page numbers may change to accommodate modifications due to variability changes.
3		Schedule of Benefits	Plan Number	Information will vary by Policyholder. The plan number is an internal convention that may be used to distinguish different benefit plans offered to policyholders. This plan number may be deleted entirely if not needed or used by the Company.
3	Eligibility		The terms, "permanent," "members," "and," and "employees" may be used to reflect policyholder specifics. Only one of the terms may be used, or the terms may be used together. Minimum weekly working hours will be between 10 and 30.	
3	Maximum Disability Benefit		The maximum disability benefit amount will be shown here. The maximum disability benefit amount will be \$3,000 per week for STD or \$10,000 per month for SDD.	
3	Maximum Covered Percent		The maximum covered percent of compensation will be shown here. This percentage may be 40, 50,	

Beazley Insurance Company, Inc.
Disability Income Master Policy (AHDIM0001 102010 Ed.)
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Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
		of Compensation	60, 66 2/3, 70 or 80.
3		Minimum Disability Benefit	The minimum disability benefit amount will be shown here. The minimum disability benefit amount will be \$25 per week for STD or \$300 per month for SDD.
3		Maximum Benefit Period	The maximum benefit period will be shown here. The maximum benefit period options for STD are 13, 26, 52 or 104 weeks. The maximum benefit period options for SDD are 6, 12, or 24 or 60 months.
3		Maximum Mental Illness Period	If the mental illness benefit is subject to a sublimit, the sublimit is listed here. The valid sublimits are 13, 26 or 52 weeks for STD or 6, 12, 24 months for SDD. If mental illness disabilities are excluded or covered with no sublimit this line is deleted in its entirety.
3		Maximum Partial Disability Benefit Period	This entire line may be deleted if Partial Disability benefits are not provided. If provided, the maximum partial disability benefit period will be shown here. Maximum partial disability benefits may be any length of time up to the Maximum Benefit Period.
3		Survivor Benefit	This entire line may be deleted if Survivor Benefits are not provided. If provided, the number of disability payments that will be paid out as a lump sum to survivors is listed here. The valid survivor benefit amounts are 3, 4, 5, 6, 9, and 12 weeks for STD and 1, 2 and 3 months for SDD.
3		Elimination Period	The elimination period will be shown here expressed in days. The accident/sickness elimination period options for STD are: 0/3, 3/3, 0/7, 7/7, 7/14, 14/14, 30/30, 60/60 or 90/90. The accident/sickness elimination period options for SDD are: 30/30, 60/60 or 90/90.
3		Waiting Period	The waiting period may 30 days or 0 days.
3		Pre-Existing Condition Period	The pre-existing condition period will be shown here. The pre-existing condition period options are 3, 6 or 12 months. If there is no pre-existing condition limitation, this line will be deleted.
3		Recurrent Disability Period	The recurrent disability period will be shown here. The recurrent disability period will vary between 3 and 12 months.
3		Rate Guarantee Period	The bracketed portion of this provision can vary between 1 and 3 years.
3		Maximum Portability Period	This line will be deleted if the Portability option benefit is not provided. If Portability is included, the length of the maximum portability period will be 12 or 24 months.
6	Definitions	Pre-Disability Monthly	This definition is included for SDD policies that pay a monthly benefit. This definition is excluded for

Beazley Insurance Company, Inc.
Disability Income Master Policy (AHDIM0001 102010 Ed.)
Statement of Variability

STD = Short Term Disability (Weekly Benefit)
SDD = Short Duration Disability (Monthly Benefit)

Page #	Section of Policy	Bracketed Section (Variables)	Description of Variability
		Compensation	STD policies that pay a weekly benefit.
6		Pre-Disability Weekly Compensation	This definition is included for STD policies that pay a weekly benefit. This definition is excluded for SDD policies that pay a monthly benefit.
8	Eligibility and Effective Date	Eligibility	The bracketed portions of this provision will be included based on policyholder specifics.
8/9		Effective Date	Language contained within brackets may be deleted in its entirety to meet policyholder specifics.
10	Disability Benefits	Introductory paragraph	The bracketed references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits. In addition, for STD policies, 1/30 th will be changed to 1/7 th .
10		Second paragraph	This sentence will be included if partial and/or residual disability benefits are provided.
10		Mental Illness Limited Benefit	If benefits for mental illness are not sublimited, this provision is not needed and will be deleted.
11		Partial Disability Benefit	If partial disabilities are not covered, this provision is not needed and will be deleted. Within the provision, the references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits. Language regarding the minimum disability benefit may be deleted on a policyholder specific basis.
11/12		Residual Disability Benefit	If residual disabilities are not covered, this provision is not needed and will be deleted. The bracketed references to month and monthly will be changed to week and weekly for STD policies that provide weekly benefits.
12/13		Rehabilitation Program Services	If Rehabilitation Services are not provided, this provision is not needed and will be deleted. Within the provision, there is a provision that makes participation mandatory. This may or may not be included base on case specifics.
13		Survivor Benefit	If survivor benefits are not provided, this provision is not needed. Within the provision, the number of days the insured must have been receiving benefits prior to death is variable. The valid values are 2 to 180 days Depending on case specifics.
13/14		Disabilities Occurring Outside the United States or Territories of the U.S.	If benefits paid to Insureds residing outside the U.S. are to be sublimited, this provision is included. The maximum number of benefits can be 1 or 2 months.

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13/14		Portability	If portability is not being provided as a benefit, this section will be deleted. Reference is made to employment or membership depending on the policy characteristics. Language regarding increasing and decreasing coverage after it is ported may be deleted depending on policyholder specifics. If the ported certificate will be allowed to continue past the termination of the Master Policy, the first reason for termination will be deleted. Language regarding billing fees may be deleted if not applicable for a particular policyholder.
14		FICA Match Benefit	If FICA match benefits are not provided, this provision will be deleted.
15	Limitations	Other Income	Language contained within brackets may be deleted in its entirety to meet policyholder specifics.
16		Pre-Existing Condition Limitation	If no Pre-Existing condition applies, this entire provision is deleted. Language regarding waiving/modifying or specifically not waiving the pre-existing condition for prior coverage may be deleted on a policyholder specific basis. Language regarding the application of the pre-existing condition to increases in coverage may be deleted on a policyholder specific basis.
17	Exclusions	Exclusions	Exclusions contained within brackets may be deleted in their entirety to meet policyholder specifics. The mental illness exclusion is deleted if mental illness coverage is provided at full or sublimited benefit amounts.
18	Termination of Insurance	Leave of Absence	Entire provision may be deleted to meet policyholder specifics. Leave of Absence period may be for up to 1 or 2 years.
19	Premium Calculation and Payment	Premium Calculation and Payment	If the Policyholder is paying 100% of the premium, the statement regarding the Insured's portion of the premium being listed on the Certificate will be deleted. Additional rate guarantees for the 4 th and 5 th year may be provided if the loss ratio in the first 3 years is less than or equal to a specified target loss ratio. If the additional rate guarantees are not provided, this language will be deleted. After the initial rate guarantee period, subsequent rate changes may not be implemented more frequently than every 6 months or longer. The number of days notice for changes in premium may vary between 30 and 90 days.
19/20		Waiver of Premium	Entire provision may be deleted to meet case specifics. The bracketed language within the provision will be varied based on policyholder specifics.