

SERFF Tracking Number: SLIA-127086253 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48317
Company Tracking Number:
TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Premier Choice - Life
Project Name/Number: Life Certificates/

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Premier Choice - Life SERFF Tr Num: SLIA-127086253 State: Arkansas
TOI: L04G Group Life - Term SERFF Status: Closed-Approved- State Tr Num: 48317
Closed

Sub-TOI: L04G.213 Specified Age or Duration - Co Tr Num: State Status: Approved-Closed
Fixed/Indeterminate Premium - Single Life
Filing Type: Form

Author: Stacy Patacsil Reviewer(s): Linda Bird
Disposition Date: 03/28/2011
Date Submitted: 03/23/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Certificates

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 03/28/2011

State Status Changed: 03/28/2011

Deemer Date:

Created By: Stacy Patacsil

Submitted By: Stacy Patacsil

Corresponding Filing Tracking Number:

Filing Description:

The following forms are being submitted for your review and approval. These are new forms.

ERAPPLIF2-9.2010 – Life Insurance 2 to 9 Product Addendum

ERAPPLIF.2010 – Life Insurance 10+ Product Addendum

ERAPPVLIF.2010 - Voluntary Life Insurance Product Addendum

GP2010LSB - Life Schedule of Benefits

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GP2010LBP-AR - Life Benefit Provisions

GP2010LSB-R – Retiree Life Schedule of Benefits

GP2010LBP-R – Retiree Life Benefit Provisions

GP2010VLSB - Voluntary Life Schedule of Benefits

GP2010VLBP-AR - Voluntary Life Benefit Provisions

The Application consists of:

- Group Application (ERAPP.2010 – approved - SLIA-127053875)
- Applicable Addenda
- Enrollment forms for all eligible employees enrolling for coverage (GB207.2010 – approved - SLIA-127053875)
- Evidence of Insurability Form, when applicable (GB215.2010 – approved - SLIA-127053875)

The Policy issued to the employer will include:

- Application
- Employer Acceptance Application (GP2010APP-AR - approved - SLIA-127053875)
- Master Policy (GP2010MP – approved - SLIA-127053875)
- Master Certificate (GP2010MC – approved - SLIA-127053875)
- Summary of Benefits and Benefit Provisions for each applicable coverage

Certificates issued to employees are comprised:

- Master Certificate
- Summary of Benefits and Benefit Provisions for each applicable coverage

The enclosed group forms provide employer-employee group insurance coverage through policies issued to employers in your state. Policies are sold by licensed agents and brokers to groups.

The coverage provided includes Life benefits on a voluntary and non-voluntary basis.

Please note that the Schedule of Benefits and any bracketed text is intended to be variable and is customized for each group policyholder.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

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Company and Contact

Filing Contact Information

Stacy Patacsil, spatacsil@securitylife.com
 25 Race Ave 888-654-7100 [Phone] 5718 [Ext]
 Lancaster, PA 17608

Filing Company Information

Security Life Insurance Company of America CoCode: 68721 State of Domicile: Minnesota
 10901 Red Circle Drive Group Code: 492 Company Type: Life, Accident &
 Health
 Minnetonka, MN 55343-9137 Group Name: State ID Number:
 (952) 544-2121 ext. 3589[Phone] FEIN Number: 41-0808596

Filing Fees

Fee Required? Yes
 Fee Amount: \$450.00
 Retaliatory? No
 Fee Explanation: \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$450.00	03/23/2011	45895863

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	03/28/2011	03/28/2011

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Disposition

Disposition Date: 03/28/2011

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		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Actuarial Memorandum		No
Form	Life 2-9 Addendum		Yes
Form	Life 10+ Addendum		Yes
Form	Voluntary Life Addendum		Yes
Form	Life Schedule of Benefits		Yes
Form	Life Benefit Provisions		Yes
Form	Retiree Life Schedule of Benefits		Yes
Form	Retiree Life Benefit Provisions		Yes
Form	Voluntary Life Schedule of Benefits		Yes
Form	Voluntary Life Benefit Provisions		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ERAPPLIF2-9.2010	Application/Life 2-9 Enrollment Form	Application/Life 2-9 Addendum	Initial		0.000	ERAPPLIF2-9.2010.pdf
	ERAPPLIF.2010	Application/Life 10+ Enrollment Form	Application/Life 10+ Addendum	Initial		0.000	ERAPPLIF.2010.pdf
	ERAPPVLI F.2010	Application/Voluntary Life Enrollment Form	Application/Voluntary Life Addendum	Initial		0.000	ERAPPVLIF.2010.pdf
	GP2010LS B	Schedule Pages	Life Schedule of Benefits	Initial		0.000	GP2010LSB.pdf
	GP2010LB P-AR	Policy/Cont ract/Fratern al Certificate	Life Benefit Provisions	Initial		0.000	GP2010LBP-AR.pdf
	GP2010LS B-R	Schedule Pages	Retiree Life Schedule of Benefits	Initial		0.000	GP2010LSB-R.pdf
	GP2010LB P-R	Policy/Cont ract/Fratern al Certificate	Retiree Life Benefit Provisions	Initial		0.000	GP2010LBP-R.pdf
	GP2010VL SB	Schedule Pages	Voluntary Life Schedule of Benefits	Initial		0.000	GP2010VLSB.pdf
	GP2010VL BP-AR	Policy/Cont ract/Fratern al Certificate	Voluntary Life Benefit Provisions	Initial		0.000	GP2010VLBP-AR.pdf

Life/AD&D Insurance 2 to 9 Product Addendum

Actively at Work — Employee Information		
Are there any employees who, on the date this application is signed, have been out of work at least 5 consecutive working days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, give details below. (Current Certificate Required)		
Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence
If more space is needed, attach a separate sheet signed and dated by the Applicant.		
To the best of the employer's knowledge, during the past 12 months, has any employee or enrolling dependent incurred medical expenses that exceeded \$10,000? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, give details below.		
Name of Employee or Dependent	Approximate Amount of Medical Expenses Incurred	Describe Nature of Injury/Illness
If more space is needed, attach a separate sheet signed and dated by the Applicant.		

Declaration	
To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.	
_____ Signature of Officer or Owner	_____ Date

<i>Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.</i>
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Home Office Use:

**Security Life Insurance Company of America
Life/AD&D Insurance 10+ Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Life Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	Current Carrier:
Coverage Information	
Class A	Class B
Class Description:	Class Description:
Weekly Work Hours Required for Eligibility : _____	Weekly Work Hours Required for Eligibility : _____
Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," Amount EMPLOYEE Contributes: _____ % for employee coverage	If "Yes," Amount EMPLOYEE Contributes: _____ % for employee coverage
Dependent Life: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Life: <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," Amount EMPLOYEE Contributes: _____ % for dependent coverage	If "Yes," Amount EMPLOYEE Contributes: _____ % for dependent coverage
Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire
Plan Information	
Class A	Class B
Base Life Benefit Amount: <input type="checkbox"/> Flat \$ _____ <input type="checkbox"/> Multiple of Salary: _____ times up to \$ _____ <input type="checkbox"/> Rounded to the next higher \$1,000	Base Life Benefit Amount: <input type="checkbox"/> Flat \$ _____ <input type="checkbox"/> Multiple of Salary: _____ times up to \$ _____ <input type="checkbox"/> Rounded to the next higher \$1,000
Annual Earnings Definition: <input type="checkbox"/> Base Annual Salary <input type="checkbox"/> Base Annual Salary plus averaged commissions <input type="checkbox"/> Other _____	Annual Earnings Definition: <input type="checkbox"/> Base Annual Salary <input type="checkbox"/> Base Annual Salary plus averaged commissions <input type="checkbox"/> Other _____
Age Reductions: <input type="checkbox"/> Reduce to 65% at age 65, 50% at 70, and 35% at 75 <input type="checkbox"/> Reduce to 65% at age 70 and 50% at age 75 <input type="checkbox"/> Reduce to 50% at age 70 <input type="checkbox"/> Other _____	Age Reductions: <input type="checkbox"/> Reduce to 65% at age 65, 50% at 70 and 35% at 75 <input type="checkbox"/> Reduce to 65% at age 70 and 50% at age 75 <input type="checkbox"/> Reduce to 50% at age 70 <input type="checkbox"/> Other _____

Life/AD&D Insurance 10+ Product Addendum

Plan Information (Continued)

If Dependent Life* Included: Spouse Amount: \$ _____
 Child (6 months to age limit) Amount: \$ _____
 Infant (14 days to 6 months) Amount: 10% of Child Amt Other \$ _____

Supplemental Life*: Included Not Included
 Incremental Benefit Option: In increments of \$10,000, up to \$ _____ or \$25,000 up to \$ _____
 Multiple of Salary Option: 1x 2x 3x 4x 5x up to \$ _____
 Flat Amount Option: \$ _____

Spouse Benefit: Included Not Included
 Spouse Life: In increments of \$5,000 to a maximum of: \$ _____ Other: \$ _____
 (not to exceed 50% of the employee's benefit amount)

Child Benefit: Included Not Included
 Child Life: In increments of \$1,000 up to a maximum of \$10,000 Other: \$ _____
 Infant child benefit (14 days to 6 months): \$500

Portability Benefit: Included Not Included

Supplemental AD&D*: Included Not Included

Dependent Supplemental AD&D: Included if both dependent supplemental life benefits and employee supplemental AD&D benefits are selected.

Common Accident Benefit (available with spouse supplemental coverage): Included Not Included

*Dependent Life, Supplemental Life, and Supplemental AD&D not available for retirees.

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Life/AD&D Insurance 10+ Product Addendum

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Voluntary Life/AD&D Insurance Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work at least 5 consecutive working days? Yes No

If Yes, give details below. (Current Certificate Required)

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance of America.

Home Office Use:

Life Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]														
Coverage Effective Date	[11/01/2010]														
Plan Effective Date	[11/01/2010]														
Open Enrollment Period	[Not Available][October 1 – October 31]														
Work Hours Required for Eligibility	Your regularly scheduled work hours must be at least [30] hours per week.														
Waiting Period	<p>For your coverage: [90] [days] [months] For your dependent coverage: [90] [days] [months]</p> <p>[Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.]</p> <p>[There will be no waiting period for employees who are actively at work and are part of the initial enrollment.]</p>														
Your Premium Contribution	<p>You are [not] required to contribute towards the cost of your coverage. [You are [not] required to contribute towards the cost of your dependent coverage.] [You are required to pay the entire cost of your supplemental coverage.]</p>														
Base Life Insurance Amount	<p>Employee: [\$10,000] [[2] times your annual earnings [, rounded to the [next higher] [\$1,000].] [plus [\$10,000]] [minus [\$10,000]] to a maximum of [\$75,000] [but not less than [\$500]].</p> <p>[Automatically reduces according to the following Reduction Schedule:</p> <table><thead><tr><th><u>Attainment of Age</u></th><th><u>Reduces To</u></th></tr></thead><tbody><tr><td>[65]</td><td>[[92%] of Scheduled Benefit][[\$10,000]</td></tr><tr><td>[66]</td><td>[[84%] of Scheduled Benefit][[\$7500]</td></tr><tr><td>[67]</td><td>[[76%] of Scheduled Benefit][[\$5000]</td></tr><tr><td>[68]</td><td>[[68%] of Scheduled Benefit][[\$2000]</td></tr><tr><td>[69]</td><td>[[60%] of Scheduled Benefit][[\$1000]</td></tr><tr><td>[70]</td><td>[[50%] of Scheduled Benefit][[\$500]</td></tr></tbody></table> <p>[to a minimum of [\$500]</p> <p>[“Scheduled Benefit” means the amount that would otherwise be payable in the absence of the Reduction Schedule.]</p>	<u>Attainment of Age</u>	<u>Reduces To</u>	[65]	[[92%] of Scheduled Benefit][[\$10,000]	[66]	[[84%] of Scheduled Benefit][[\$7500]	[67]	[[76%] of Scheduled Benefit][[\$5000]	[68]	[[68%] of Scheduled Benefit][[\$2000]	[69]	[[60%] of Scheduled Benefit][[\$1000]	[70]	[[50%] of Scheduled Benefit][[\$500]
<u>Attainment of Age</u>	<u>Reduces To</u>														
[65]	[[92%] of Scheduled Benefit][[\$10,000]														
[66]	[[84%] of Scheduled Benefit][[\$7500]														
[67]	[[76%] of Scheduled Benefit][[\$5000]														
[68]	[[68%] of Scheduled Benefit][[\$2000]														
[69]	[[60%] of Scheduled Benefit][[\$1000]														
[70]	[[50%] of Scheduled Benefit][[\$500]														

Life Insurance

Schedule of Benefits

[Base Accidental Death and Dismemberment Principal Sum Amount

Employee: [\$10,000] [[2] times **your annual earnings** [, rounded to the [next higher] [\$1,000],] [plus [\$10,000]] [minus [\$10,000]] to a maximum of [\$75,000] [but not less than [\$500]].

[Automatically reduces according to the following Reduction Schedule:

<u>Attainment of Age</u>	<u>Reduces To</u>
[65]	[[92%] of Scheduled Benefit][[\$10,000]
[66]	[[84%] of Scheduled Benefit][[\$7500]
[67]	[[76%] of Scheduled Benefit][[\$5000]
[68]	[[68%] of Scheduled Benefit][[\$2000]
[69]	[[60%] of Scheduled Benefit][[\$1000]
[70]	[[50%] of Scheduled Benefit][[\$500]
	[to a minimum of [\$500]]

[“Scheduled Benefit” means the amount that would otherwise be payable in the absence of the Reduction Schedule.]

[Base Accidental Death and Dismemberment Additional Benefits

Air Bag Benefit - Included
 Brain Damage Benefit – [Included] [Not Included]
 Coma Benefit – [Included] [Not Included]
 Education Benefit -[Included] [Not Included]
 [Exposure and Disappearance Benefit – [Included][Not Included]]
 Felonious Assault Benefit – [Included] [Not Included]
 [Home Alteration and Vehicle Modification Benefit – [Included] [Not Included]]
 Public Transportation Benefit - [Included] [Not Included]
 Repatriation Benefit - Included
 Seat Belt Benefit - Included]

Base Guarantee Issue Amount

[\$50,000][Amounts in excess of [\$50,000] require **our** approval of **your evidence of insurability.**] [Does not apply.]

Dependent Coverage

[Not] Included

[Dependent Life Insurance Amounts

[Spouse: [\$5,000] [but not to exceed [50%] of Base Life Insurance Amount]]
 [Child [6] months to [19] years: [\$2,500] [but not to exceed [10%] of Base Life Insurance Amount]
 Infant Child, [14] days to [6] months: [\$100] [[10%] of Child Life Insurance Amount]]

[Dependent Student Age Limit

[23] years]

Life Insurance

Schedule of Benefits

[Supplemental Life Insurance Amounts

Employee: [Supplemental Life Insurance Amount up to [\$200,000], [in increments of [\$10,000]], not to exceed [4] times **your annual earnings** when combined with **your** Base Life Insurance Amount]
[Supplemental Life Insurance Amount up to [2] times **your annual earnings** to a maximum of [\$200,000], not to exceed [4] times **your annual earnings** when combined with **your** Base Life Insurance Amount].

[Spouse: Supplemental Life Insurance Amount [in increments of [\$10,000,]] [up to [\$20,000,]] [not to exceed [50]% of **your** approved Supplemental Life Insurance Amount]].

[Child, [6] months to [19] years: Supplemental Life Insurance Amount [in increments of [\$5,000,]] [up to [\$20,000,]] [not to exceed [10]% of **your** approved Supplemental Life Insurance Amount].

Infant Child, [14] days to [6] months: [\$100][[10%] of Child Supplemental Life Insurance Amount.]]

Supplemental Life Insurance Amounts automatically reduce according to the following Reduction Schedule:

<u>Attainment of Age</u>	<u>Reduces To</u>
[65]	[92%] of Scheduled Benefit
[66]	[84%] of Scheduled Benefit
[67]	[76%] of Scheduled Benefit
[68]	[68%] of Scheduled Benefit
[69]	[60%] of Scheduled Benefit
[70]	[\$0]

[“Scheduled Benefit” means the amount that would otherwise be payable in the absence of the Reduction Schedule.]]

[Supplemental Accidental Death and Dismemberment Amounts

Employee: [Supplemental Accidental Death and Dismemberment Amount up to [\$200,000], [in increments of [\$10,000]], not to exceed [4] times **your annual earnings** when combined with **your** Base Accidental Death and Dismemberment Principal Sum Amount]
[Supplemental Accidental Death and Dismemberment Amount up to [2] times **your annual earnings** to a maximum of [\$200,000], not to exceed [4] times **your annual earnings** when combined with **your** Base Accidental Death and Dismemberment Principal Sum Amount].

[Spouse: Supplemental Accidental Death and Dismemberment Amount [in increments of [\$10,000,]] [up to [\$20,000,]] [not to exceed [50]% of **your** approved Supplemental Accidental Death and Dismemberment Amount]].

[Child, [6] months to [19] years: Supplemental Accidental Death and Dismemberment Amount [in increments of [\$5,000,]] [up to [\$20,000,]] [not to exceed [10]% of **your** approved Supplemental Accidental Death and Dismemberment Amount].

Infant Child, [14] days to [6] months: [\$100][[10%] of Child Supplemental Accidental Death and Dismemberment Amount.]]

Schedule of Benefits

Supplemental Accidental Death and Dismemberment Amounts automatically reduce according to the following Reduction Schedule:

<u>Attainment of Age</u>	<u>Reduces To</u>
[65]	[92%] of Scheduled Benefit
[66]	[84%] of Scheduled Benefit
[67]	[76%] of Scheduled Benefit
[68]	[68%] of Scheduled Benefit
[69]	[60%] of Scheduled Benefit
[70]	[\$0]

["Scheduled Benefit" means the amount that would otherwise be payable in the absence of the Reduction Schedule.]

[Supplemental Accidental Death and Dismemberment Additional Benefits

Air Bag Benefit - Included
 Brain Damage Benefit – [Included] [Not Included]
 Coma Benefit – [Included] [Not Included]
 Common Accident Benefit – [Included] [Not Included]
 Education Benefit -[Included] [Not Included]
 [Exposure and Disappearance Benefit – [Included] [Not Included]]
 Felonious Assault Benefit – [Included] [Not Included]
 [Home Alteration and Vehicle Modification Benefit – [Included] [Not Included]]
 Public Transportation Benefit - [Included] [Not Included]
 Repatriation Benefit - Included
 Seat Belt Benefit - Included]

[Supplemental Guarantee Issue Amount

[\$50,000] for employee [or [\$20,000] for spouse] [Amounts in excess of [\$100,000] for employee [or [\$20,000] for spouse] will require our approval of **evidence of insurability.**] [Does not apply.]

Accelerated Benefit

Included

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence

[Temporary Layoff – [Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.] [Up to [3] months after **your** last day of **active work.**]]

Injury or Illness –
 [Up to [2] months after **your** last day of **active work.**]
 [The lesser of [2] months after **your** last day of **active work**, or attainment of age 65.]
 [To age 65.]

(up to 12 weeks for a leave under the Family and Medical Leave Act)

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Refer to Conversion Privilege for continuation beyond what is specified above.

Annual Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions prior to the date of **your** death or the date **your** disability began, but excluding commissions, bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including commissions averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including commissions and bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding commissions, overtime pay and other extra compensation.]

[**Your** gross earnings from the **covered employer** as shown on **your** W-2 from the **covered employer** for the preceding **calendar year**.]

[For 1099 income, **your** earnings from the **covered employer** as reported on the 1099-Misc of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a 1099-Misc for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.]

For partners, **your** average earnings from the partnership calculated from the "net earnings from self-employment" section on Schedule K-1 of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a Schedule K-1 for the preceding **calendar year** or tax year, **we** will annualize **your** earnings using the number of months worked.

For sole proprietors, **your** annual net profit as shown on **your** Form 1040-C for the preceding **calendar year** or tax year excluding depreciation and expenses for business use of **your** home. If **you** did not file a Form 1040-C for the preceding **calendar year** or tax year, **we** will annualize **your** earnings using the number of months worked.

For shareholders of an S Corporation, **your** average earnings as an insured shareholder based on:

1. the "Wages, Tips and Other Compensation" of **your** Form W-2 and including compensation deferral reported on **your** Form W-2 received from the **covered employer**:

- a. for the **calendar year** immediately prior to the date of **your**

- b. death or the date **your** disability began; or
- b. for the period of employment with the **covered employer** if **you** did not receive a W-2 Form prior to the date of **your** death or the date **your** disability began; and

- 2. **your** ordinary income or loss from trade or business activities from Schedule K-1 of **your** federal income tax return from the **covered employer** for the year immediately prior to the date of **your** death or the date **your** disability began.

If **you** have not been a shareholder for the year for which the most recent S Corporation federal income tax return was filed, **your** earnings will be based on the period of actual employment during which **you** were a shareholder.

Annual earnings does not include income received from sources other than as a shareholder of the **covered employer**.

Beneficiary

The person designated by **you** to receive the proceeds of **your coverage** upon **your** death.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage**]

[Dependent

Your:

- 1. spouse;
- 2. unmarried **children** from [14 days] to [age 19] [who are primarily dependent upon **you** for support and maintenance];
- 3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
 - a. a full-time student at an accredited school;
 - b. primarily dependent upon **you** for support and maintenance;
 - c. not married; and
 - d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;

and

- [4.] **child** after their [19th] birthday if the **child** has been continuously Insured and is:

- a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
- b. primarily dependent upon **you** for support and maintenance; and
- c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:
 - a. joint mortgage or joint tenancy on a residential lease;
 - b. joint bank account;
 - c. joint liabilities (e.g. credit cards or car loans);
 - d. joint ownership of significant property (e.g. cars, land, etc.)
 - e. naming of each other as primary beneficiary in wills or life insurance policies;
 - f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
 - g. commitment to a long term relationship with the intention of remaining together indefinitely.

All references to spouse include **domestic partner**.]

Evidence of Insurability

A statement of **your** [or **your dependent's**] medical history and evidence of good health which **we** will use to determine if **you** [or **your dependent**] are approved for **coverage**.

Evidence of insurability will be provided at **your** expense.

Illness

Your medically determinable sickness, disease or pregnancy.

[Disability resulting from **illness** must begin while **you** are covered under the **policy**.]

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Injury which occurs before **you** are covered under the **policy** will be treated as an **illness**. [Disability must begin while **you** are covered under the **policy**.]

Late Enrollment

You enroll for **coverage** more than 31 days after the date **you** initially become eligible for **coverage**.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**, including any increase in **coverage** due to an increase in **annual earnings** of 10% or more.

Physician

A person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery and is operating within the scope of his or her license; or
2. is legally qualified as a medical practitioner and required to be recognized by the insurance laws of the governing jurisdiction.

A **physician** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

Total Disability

You are unable to perform the duties of any occupation for which **you** are or become qualified by education, training or experience because of **injury** or **illness**.

Treatment

Includes:

1. consulting with or receiving advice from a **physician**;
2. receiving care or services from a **physician** or from other medical professionals a **physician** recommends **you** see;

3. being prescribed medicines, whether or not **you** choose to take them;
 4. refilling prescribed medicines; or
 5. receiving diagnostic measures or services.
-

Effective Date of your Life Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. the Evidence of Insurability Requirement, if applicable.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage** or any **new coverage**, if **you** enroll on or before that date or within 31 days after **your** eligibility date; or
2. the date **we** approve **your evidence of insurability**, if applicable.

Increases or decreases in **your coverage** amount due to changes in class or earnings will become effective on the date **you** begin **active work** in the new class or at the new earnings level.

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a **late enrollment**, if **you** contribute toward the cost of **your coverage**, **you** must satisfy the Evidence of Insurability Requirement for **your coverage** to become effective.]

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a **late enrollment**:

1. **you** must satisfy the Evidence of Insurability Requirement for **your coverage** to become effective; and
2. **you** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits.]

Evidence of Insurability Requirement

When **we** request **evidence of insurability** as a condition for **your coverage** or for any **new coverage**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as a part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. for **late enrollment**; or
2. if **you** voluntarily terminated **your coverage** and are re-enrolling; or
3. if **you** apply for amounts in excess of the Guarantee Issue Amount shown in the Schedule of Benefits; or
4. for amounts **you** request to increase **your** Life Insurance Coverage Amount; or
5. for an increase in coverage due to an increase in **annual earnings** of 10% or more.

If approved, **your coverage** or **new coverage** will become effective on the date **we** approve **your** application.

Termination of your Life Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. [the date][the end of the month in which] **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence [and][the Portability Benefit].

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a continuation of coverage under the **policy** due to a **total disability** that began prior to the date of the termination.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work** and is subject to the reductions in benefits of that **eligible class**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will apply any prior period of work with **your covered employer** toward the **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured; and
4. [if **you** elected to port **your coverage** under the Portability Benefit or] if a life insurance conversion policy was issued, **you** must surrender the [portability coverage or] conversion policy without claim.

All other **policy** provisions apply.

[Continuation of Coverage During Total Disability

QUALIFYING FOR CONTINUATION OF COVERAGE

Your coverage will continue during a period of **total disability** if:

1. **your total disability** begins while **your coverage** is effective and **you** are under age [60]; and
2. **your total disability** has been continuous during a [9-month] waiting period; and
3. **you** or a person acting on **your** behalf notifies **us** of **your total disability** within 12 months after the date **your total disability** begins;

and

4. **we** approve **your** claim for **total disability**.

If **you** die during the [9-month] waiting period, and **you** would have otherwise qualified for continuation, the waiting period will be considered satisfied.

If **you** are over age [60] when **your total disability** begins, **you** are not entitled to continue your **coverage** under this provision, and **coverage** will terminate as shown in Termination of Your Life Coverage.

[This provision is not applicable to **your dependents**.]

AMOUNT OF LIFE INSURANCE CONTINUED

The amount of **your** life insurance that will be continued during **your total disability** is the amount of **your** life insurance on **your** last day of **active work**. This amount will continue to be subject to the scheduled reductions and termination shown in the Schedule of Benefits. This amount will be further reduced by the amount of any individual policy issued to **you** pursuant to the Conversion Privilege and any amount paid under the Accelerated Benefit provision.

NOTICE AND PROOF OF TOTAL DISABILITY

You or a person acting on **your** behalf must provide **us** with written notice and the first proof of **total disability** at **our home office** within 12 months after **your total disability** begins. If **we** request written proof of **total disability** after the first proof, **you** must provide **us** with the required written proof within 3 months after the date of request.

You must give **us** proof of **total disability** as often as **we** deem reasonably necessary. After the first two years of **total disability**, **we** will not require proof more than once a year. As part of this proof, **we**, at **our** expense, may require that **you** get an examination. This examination must be made by a **physician** approved by **us**.

If it is not possible to give **us** notice or proof of **your total disability** within these time limits, **you** must give **us** the proof as soon as reasonably possible. The notice may not be given more than 3 months later than the time that either the notice or proof is required.

If **you** die before **you** first submit proof, the proof must be submitted with the proof of death.

TERMINATION OF YOUR CONTINUED LIFE INSURANCE

Your continued life insurance will terminate on the earliest of the following dates:

1. the date **you** are no longer totally disabled; or
2. the date **you** fail to give **us** written proof of continued **total disability** within the time required; or

3. the date **you** attain age [65].

If **your** continued life insurance terminates (unless **you** become a **covered person** again), **you** may exercise the Conversion Privilege. This privilege will apply as if **you** were no longer in an **eligible class** on the date **your** continued life insurance terminated.

WAIVER OF PREMIUM

Premium will not be payable during any period that **you** are totally disabled and **your total disability** has been approved by **us**.]

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group life insurance plan (the “Prior Plan”); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy** through the date **your** disability began or **your** date of death.

[If **you** are not **actively at work** due to [injury][,][or][illness][,][or][leave of absence][,][or][temporary layoff] on the effective date of the **policy**, **we** will provide Continuity of Coverage if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy**. **We** will provide limited coverage under this Continuity of Coverage provision.

Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your coverage** is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy**.

We will provide **coverage** according to the terms of the Prior Plan, less any benefits for which the Prior Plan is liable.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will not begin before **you** return to **active work**.]

]

[Life Coverage – for your Dependents]

Effective Date of your Dependent Life Coverage

Your **dependent coverage** or any **new coverage** with respect to **dependent coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Life Coverage;
2. the Enrollment Requirement for your Dependent Life Coverage; and
3. the Evidence of Insurability Requirement for your Dependent Life Coverage, if applicable.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** within 31 days after your **dependent's** eligibility date; or
2. the date **we** approve **your dependent's evidence of insurability**, if applicable.

The effective date will be deferred for a **dependent** if they are in a medical care facility, or are in a period of limited activity due to an **illness** or **injury**, when the **coverage** is due to become effective. In this case, the **coverage** will become effective on the first day of the month following the date the **dependent** has been free from confinement for 7 consecutive days and/or returned to normal activities.

Eligibility Requirement for your Dependent Life Coverage

You will be eligible for **dependent coverage** on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

Enrollment Requirement for your Dependent Life Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective.

[If **you** submit a **late enrollment** for a **dependent**, **you** will be required to submit **evidence of insurability** before the **coverage** on that **dependent** can become effective.]

[If **you** submit a **late enrollment** for a **dependent**:

1. **you** will be required to submit **evidence of insurability** before the **coverage** on that **dependent** can become effective; and
2. **you** can enroll **your dependent** only during the Open Enrollment Period shown in the Schedule of Benefits.]

Evidence of Insurability Requirement for your Dependent Life Coverage

When **we** request **evidence of insurability** as a condition for **coverage** or for any **new coverage** on **your dependent**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. if **you** are enrolling for **dependent coverage** more than 31 days after the date **your dependents** are eligible for **coverage**; or
2. if **you** voluntarily terminated **your dependent coverage** and are re-enrolling; or
3. [if **you** apply for **dependent** amounts in excess of the Guarantee Issue Amount shown in the Schedule of Benefits; or]
4. for amounts **you** request to increase **your dependent coverage** amounts.

If approved, **your coverage** will become effective on the date **we** approve **your** application.

Effective Date of Changes in Your Dependent Life Coverage Amount

An increase in **your dependent** life insurance amount will become effective as follows:

Benefit Change due to Change in Age: The change will become effective at 12:00 a.m. on the date of the change in age.

Benefit Change due to Change in Your Life Insurance Amount: The change will become effective at 12:00 a.m. on the same date as the change in **your coverage**.

The effective date of an increase in **your dependent coverage** amount will be deferred for a **dependent** if they are in a medical care facility, or are in a period of limited activity due to an **illness** or **injury** when the **new coverage** is due to become effective. In this case, the **new coverage** will become effective on the first day of the month following the date the **dependent** has been free from confinement for 7 consecutive days and/or returned to normal activities.

Termination of your Dependent Life Coverage

Coverage on **your dependents** will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
 2. the date **your dependent coverage** is discontinued under the **policy**; or
 3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**, or
 4. the last day for which **you** make a required premium payment.
-

Death Benefit

If **you** [or **your covered dependent**] die while **coverage** is effective under the **policy**, **we** will pay a death benefit to the **beneficiary** upon receipt of proof of death acceptable to **us**. This death benefit will be the amount of life insurance in force at the time of death.

Beneficiary

[Subject to the Assignment provision,] **you** have the right to name or change **your beneficiary**. Unless **we** receive (or **your covered employer** receives) a written and signed **beneficiary** designation or if **your** designated **beneficiary** is deceased at the time of **your** death, **your beneficiary** will be determined based on the following order:

1. **your** spouse, if living,
2. **your children**, if living, equally, or
3. **your** estate.

[The **beneficiary** for **your covered dependents** will be **you**.]

[Assignment

You may assign **your** rights to **your** life insurance provided that:

1. the assignment is made in writing on a form acceptable to **us**; and
2. **we** receive and register the assignment.

We are not responsible for the validity of the assignment. [**Dependent coverage** is not assignable.]]

[Exclusion

Benefits will not be payable if **your** death [or the death of **your covered dependents**] is caused by or results from suicide, whether sane or insane, within two years from the date **your coverage** [or **your dependent coverage**] becomes effective.]

Portability Benefit

When Portability Applies:

Portability is **your** right to continue insurance for **yourself** [and **your covered dependents**] at the time **your** [base life] [and] [supplemental life] **coverage** ends. **Coverage** continued under this provision is subject to all other provisions and limitations of the **policy** unless specifically noted otherwise.

You [and **your covered dependents**] may continue **coverage** provided that:

1. **you** are under the age of [60], and
2. **you** have been continuously covered under the **policy** for at least [12] months prior to the date **coverage** terminates; and
3. **coverage** ends for any reason other than:
 - a. termination of the **policy** by the **covered employer**;
 - b. **your** retirement;
 - c. termination due to **your** disability[.] [or death];
 - d. termination due to divorce or legal separation where recognized by state law.]

[You must elect portability to have portable coverage for your covered dependents.]

[You must elect portability for your Base Life insurance in order to elect portability for Supplemental Life insurance]

Amount of Insurance:

You [and **your covered dependents**] may continue **coverage** up to the amount terminated. Waiver of Premium, Accidental Death and Dismemberment Benefits and Accelerated Death Benefits are not available.

Notice of Portability Rights:

Your covered employer will deliver a notice at least 15 days prior to the end of the portability period.

You must submit an application [and pay the required premium] to **us** within 31 days after **coverage** ends. If **you** do not elect this Portability Benefit within 31 days after **coverage** ends, **you** may not elect to port **coverage** at a later date.

Premium:

The premium for this **coverage** will be based on the rate(s) in force for the **policy**.

Limitations and Termination:

Coverage under this Portability Benefit will terminate on the earliest of:

1. the date the **covered employer** cancels **coverage** for all members of the class **you** were covered under when **your coverage** terminated;

2. the day after the end of the period for which premium is paid;
3. **your** attainment of age [65];
4. the date the **policy** terminates;
5. the date **you** re-enroll or are reinstated under the **policy** as an **active employee**.

Coverage will reduce in accordance with the age Reduction Schedule in the Schedule of Benefits. Conversion Privilege will apply if **coverage** ends due to:

1. reaching termination age;
2. termination of **coverage** for all members of the class **you** were covered under when **your coverage** terminated;
3. termination of the **policy** by the **covered employer**.

If **coverage** terminates due to nonpayment of premium, the Conversion Privilege will not apply.

Conversion Privilege

When the Conversion Privilege Applies.

1. **You [or your covered dependents]** are entitled to convert **your coverage [or your dependent coverage]** to an individual life insurance policy if **coverage** or any portion of it terminates due to:
 - a. termination of **your** employment; or
 - b. reduction in benefits; or
 - c. loss of eligibility[.] [;or
 - d. loss of eligibility as a **dependent.**]

You [or your covered dependents] are entitled to convert any amount up to the amount that terminated.

2. **You [or your covered dependents]** are also entitled to convert **your coverage [or your dependent coverage]**, provided **you [or your covered dependents]** have been continuously insured under the **policy** or any policy it replaced for at least [5] years prior to termination.
 - a. **You [or your covered dependents]** are entitled to convert to an individual life insurance policy if **coverage** terminates due to:
 - i. termination of the **policy**; or
 - ii. amendment of the **policy** to terminate[.]; or
 - iii. amendment of the **policy** to remove **dependent** benefits].
 - b. **You [or your covered dependents]** can convert up to the lesser of:
 - i. [\$10,000]; or
 - ii. the amount of life insurance that terminates. This amount will be reduced by any new life insurance for which **you [or your covered dependents]** become eligible under any other group policy within 31 days of termination of **coverage** under the **policy**.

Type of Conversion Policy Available. The conversion policy will be one of the individual life insurance policies, other than term insurance, then offered by **us**. The conversion policy will not include Waiver of Premium, Accidental Death and Dismemberment Benefits and Accelerated Death Benefits. It will be issued without **evidence of insurability**.

Effecting a Conversion: The conversion policy will become effective at the end of the 31-day conversion period after the life insurance terminates. To convert, **you [or your covered dependent]** must submit the following information during that conversion period:

1. a written application; and
2. the first premium payment.

Notice of Right to Convert. **Your covered employer** will deliver a notice at

least 15 days prior to the end of the conversion period. If **you** do not receive at least 15 days notice, **we** will extend the conversion period so that **you** will be given at least 15 days to decide whether to convert the **coverage**. This additional period will not extend beyond 60 days after the end of the 31-day conversion period. This extension does not continue **coverage** beyond the 31-day conversion period.

The premium for the conversion policy will be at the customary rate for:

1. that policy and that amount of insurance; and
2. the class of risk; and
3. the age on the individual policy's effective date.

Re-employment After Conversion. In order to obtain **coverage** again under the **policy** after a conversion policy has been issued, **you** must either: (a) surrender the conversion policy without claim; or (b) submit **evidence of insurability** to **us**.

Death Benefit. If **you** [or **your covered dependent**] die during the 31-day conversion period, the amount of the death benefit will be the maximum amount of life insurance that could have been converted.

Life Insurance

Accelerated Benefit - for Limited Life Expectancy

Important information about your Accelerated Benefit:

Payment of an Accelerated Benefit may be taxable. If you receive payment of an Accelerated Benefit, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplementary Security, Supplemental Security Income (SSI), and others. You should seek assistance from a personal tax advisor regarding taxes you may have to pay as the result of claiming an Accelerated Benefit.

Requirements

You will be entitled to accelerate **your** Death Benefit under the **policy**, if **you** have been diagnosed with a terminal condition, as certified by a **physician**, while insured under the **policy**.

To receive this benefit, **you** must:

1. make a written request on a form acceptable to **us**; and
2. submit medical evidence acceptable to **us** that **you** have a terminal condition.

At **our** expense, **we** have the right to ask for a medical examination in connection with a claim.

"Terminal condition" means that **you** are expected to have 12 months or less to live, as certified by a **physician**.

You will not be eligible for the Accelerated Benefit if **your** life insurance is scheduled to reduce or end as shown in the Schedule of Benefits within 24 months following the date **you** make application for the Accelerated Benefit.

Administrative Charge

At the time **you** receive **your** Accelerated Benefit, **we** will deduct [\$250] from the amount of **your** Accelerated Benefit as an administrative charge.

Amount payable

We will pay **you** up to the lesser of:

1. [50%] of **your** life insurance amount that is in force at the time of the request; or
2. [\$250,000.]

You can choose to take less than [50%] of **your** life insurance amount, but **you** may receive an Accelerated Benefit only once in **your** lifetime. The minimum amount that **you** may choose to receive is [25%] of **your** life insurance amount.

To whom payable

The Accelerated Benefit is payable only to **you**.

Method and Timing of Payment

The Accelerated Benefit is payable in a lump sum. It will not be paid if **you** die before payment is made. At the time **we** pay **you** the Accelerated Benefit, **we** will provide **you** with a benefit payment notice informing **you** of the amount of

Life Insurance

Accelerated Benefit - for Limited Life Expectancy

your Accelerated Benefit, the amount of the administrative charge, and the amount of insurance remaining.

Effect on Life Coverage

The amount of **your** life insurance will be reduced by:

1. any benefit paid to **you**; plus
 2. the amount of the administrative charge.
-

Life Conversion

If **your** life insurance terminates, **you** may convert **your** life insurance amount remaining after reduction of the Accelerated Benefit, subject to the provisions of the Conversion Privilege.

Reductions

If **you** are subject to an age reduction after payment of the Accelerated Benefit, the reduction will be applied to the original face amount. Upon death, the benefit payable will be the reduced benefit, minus the Accelerated Benefit payment.

If **your** life insurance benefit reduces, the amount of the Accelerated Benefit plus the corresponding death benefit will never exceed the amount that would have been paid had there not been an Accelerated Benefit.

If **you** recover and return to **active work**, **your** Life Insurance Amount will remain reduced by the accelerated benefit approved by **us**.

[Accidental Death and Dismemberment]

Effective Date of your [and your Dependent] Accidental Death and Dismemberment Coverage

Your [and your dependent] accidental death and dismemberment **coverage** will become effective on the later of the following dates:

1. the date that **your** [and **your dependent**] life insurance becomes effective; or
2. the date that the **policy** is amended to include accidental death and dismemberment **coverage** for **your eligible class** [or for eligible **dependents**].

Termination of your [and your Dependent] Accidental Death and Dismemberment Coverage

Your [and your dependent] accidental death and dismemberment **coverage** will terminate on the earliest of the following dates:

1. the date **your** [and **your dependent**] life insurance terminates; or
2. the date the **policy** is amended to terminate **your** [and **your dependent**] accidental death and dismemberment **coverage**; or
3. the date **your** [and **your dependent**] accidental death and dismemberment **coverage** terminates as shown in the Schedule of Benefits.

Benefit Payable

Benefits will be paid according to the following:

1. When **you** [or **your dependent**] have a Covered Loss, **we** will pay a benefit as shown in the Table of Losses.
2. The "Principal Sum Amount" is the amount shown in the Schedule of Benefits.
3. These benefits are payable in accordance with the Claims Provisions.

Covered Loss

A loss shown in the Table of Losses that meets all of the following conditions:

1. The Covered Loss results directly from an **injury** and must be independent of all other causes. This **injury** must be caused by an accident that occurs while **your** [or **your dependent**] **coverage** is effective.
2. The Covered Loss must not be excluded under Exclusions.
3. The Covered Loss, except for loss of life, must occur no more than 90 days after the date of the **injury**.

Table of Losses

IN THE EVENT OF LOSS OF:

THE BENEFIT WILL BE:

Life

The Principal Sum Amount

Hand, foot or eyesight:

1. any single loss:

One Half of the Principal Sum Amount

2. more than one loss from any one accident:

The Principal Sum Amount

[Accidental Death and Dismemberment]

For the loss of a hand or foot, there must be actual severance at or above the wrist or ankle joint.

Loss of sight of an eye means the eye is totally and irreversibly blind.

IN THE EVENT OF LOSS
RESULTING IN:

THE BENEFIT WILL BE:

Quadriplegia

The Principal Sum Amount

Paraplegia

One Half of the Principal
Sum Amount

Hemiplegia

One Half of the Principal
Sum Amount

IN THE EVENT OF LOSS OF:

Use of Both Hands or Both
Legs

One Half of the Principal Sum Amount

Use of One Hand or One Leg

One Fourth of the Principal
Sum Amount

We will not pay an accidental death and dismemberment benefit for any paralysis caused by a stroke.

IN THE EVENT OF LOSS OF:

THE BENEFIT WILL BE:

Speech and Hearing

The Principal Sum Amount

Speech or Hearing

One Half of the Principal
Sum Amount

Hearing in One Ear

One Fourth of the Principal
Sum Amount

Loss must be determined by a **physician** to be permanent, complete and irreversible.

The Maximum Amount payable for all losses from any one accident will be the Principal Sum Amount.

Air Bag Benefit

If the benefit is payable under the Seat Belt Benefit and the automobile is equipped with a factory installed air bag system, an additional benefit will be paid of the lesser of [5%] of **your** [or **your dependent**] Accidental Death and Dismemberment Principal Sum Amount or [\$5,000] if:

1. **you** [or **your covered dependent**] were positioned in a seat that is designed to be protected by an air bag; and
2. the air bag inflated properly upon impact and is certified in the official accident report, or by the investigating officer. A copy of the report must be submitted with the claim.

[Accidental Death and Dismemberment]

[This provision is not applicable to **your covered dependents.**]

[Brain Damage Benefit

If **you** [or **your covered dependent**] sustain an **injury** which, independent of all other causes, directly results in the traumatic brain injury causing brain damage, **we** will pay a benefit equal to the lesser of [5%] of **your** [or **your covered dependent**] Accidental Death and Dismemberment Principal Sum Amount or [\$5000], if all of the following conditions are met:

1. the brain damage begins within 60 days of the **injury**; and
2. the brain damage continues for 12 consecutive months; and
3. a **physician** certifies the brain damage is permanent and irreversible at the end of the 12 consecutive

Payment of the Brain Damage Benefit plus any other benefits payable as a result of the same accident will not exceed the Accidental Death and Dismemberment Principal Sum Amount the insured is eligible to receive.

“Brain Damage” means a traumatic brain injury which causes the complete inability to perform all of the Activities of Daily Living.

“Activities of Daily Living” means:

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

A person is considered unable to perform an activity of daily living if the task cannot be performed safely without another person’s stand-by assistance or verbal cueing.

[This provision is not applicable to **your covered dependents.**]

[Coma Benefit

If **you** [or **your covered dependent**] sustain an **injury** which, independent of all other causes, directly results in a coma, **we** will pay a benefit equal to the lesser of [5%] of **your** [or **your covered dependent**] Accidental Death and Dismemberment Principal Sum Amount or [\$5,000], if all of the following conditions are met:

[Accidental Death and Dismemberment]

1. **You** [or **your covered dependent**] must remain in a coma for 31 continuous days; and
2. the onset of the coma must occur within 31 days of the accident.

Payment of the Coma Benefit plus any other benefits payable as a result of the same accident will not exceed the Accidental Death and Dismemberment Principal Sum Amount the insured is eligible to receive.

“Coma” means a profound stupor or state of complete and total unconsciousness, as the result of an accident.

[This provision is not applicable to **your covered dependents.**]

[Common Accident Benefit

If **you** and **your** covered spouse die within [3 months] from a Common Accident and are survived by one or more dependent **children, we** will increase **your** covered spouse’s Accidental Death and Dismemberment Principal Sum Amount to 100% of Your Accidental Death and Dismemberment Principal Sum Amount.

“Common Accident” means the same Covered Loss or separate Covered Loss that occur within the same 24 hour period.]

[Education Benefit

If an accidental death benefit is payable for loss of **your** [or **your covered dependent’s**] life, an additional benefit of [\$2,500] will be paid per academic term for a maximum of 8 payments to **your dependent** student. This benefit will be payable, subject to satisfactory proof, for each qualifying **dependent child** for post-secondary education expenses. [If both parents die as a result of the same accident, the maximum benefit payable is [\$2,500] per academic term for a maximum of 8 payments.]

“Student” means a **dependent child** who, on the date of **your** death:

1. is already enrolled full-time in an education program; or
2. is at a secondary school level but will enroll as a full-time student in a post-secondary education program within 365 days of **your** death.

"Post-secondary education" includes any accredited institution of higher learning beyond the 12th grade level. The **dependent child** must be a full-time student as defined by the institution.

If your **dependent child** satisfies the above requirements, any benefits payable will be paid to the person having primary responsibility for these expenses.

The Education Benefit will terminate for each **dependent** student on the earliest of the following dates:

1. the date the **dependent** student failed to furnish proof of full-time enrollment as required by **us**; or
 2. the date the **dependent** student no longer qualifies as a **dependent child** for any reason except **your** death; or
-

[Accidental Death and Dismemberment]

3. the end of the maximum benefit period.

[This provision is not applicable due to the death of **your dependents.**]

[Exposure and Disappearance Benefit

We will pay an exposure benefit when **you** [or **your covered dependent**] experience a loss which results from unavoidable exposure to the elements. The loss must be listed in the Table of Losses. The benefit is paid according to the applicable percentage listed in the Table of Losses.

If **you** [or **your covered dependent**] disappear as a result of a forced landing, stranding, sinking or wrecking of any conveyance in which **you** [or **your covered dependent**] are traveling, and **you** [or **your covered dependent**] are not found within one year of the accident, **you** [or **your covered dependent**] will be presumed to have died in the accident. The amount payable for disappearance will be **your** [or **your Dependent**] Accidental Death and Dismemberment Principal Sum Amount.

[This provision is not applicable to **your covered dependents.**]

[Felonious Assault Benefit

We will pay an additional benefit equal to the lesser of [5%] of Your Accidental Death and Dismemberment Principal Sum Amount or [\$5,000] if a Covered Loss:

- 1) occurs while **you** are in the act of conducting business for or on any premises of the policyholder; and
- 2) is inflicted by persons other than fellow employees or members of **your** family or household; and
- 3) is the direct result of any of the following:
 - a. actual or attempted robbery or holdup;
 - b. actual or attempted kidnapping; or
 - c. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

“Fellow Employee” means a person employed by the same Employer or by an Employer that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined felonious assault was committed.

“Members of **your** family ” means **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

“Members of your household” means a person who maintains residence at the same address as **you.**]

[Home Alteration and Vehicle

If a Covered Loss occurs, except for loss of life, and it requires a home or vehicle to be modified, **we** will pay an additional benefit equal to the lesser of

[Accidental Death and Dismemberment]

Modification Benefit

10% of Your [or **your** Dependent] Accidental Death and Dismemberment Principal Sum Amount or \$10,000, if all of the following conditions are met:

1. Prior to the date of the Covered Loss, **you** [or **your covered dependent**] did not require the use of any adaptive devices or adaptation of residence and/or vehicle; and
2. As a direct result of such Covered Loss, **you** [or **your covered dependent**] now require such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. **You** [or **your covered dependent**] require home alteration or vehicle modification within one year of the date of the Covered Loss.

[This provision is not applicable to **your covered dependents.**]]

[Public Transportation Benefit

An additional benefit will be paid, equal to the lesser of **your** [or **your dependent**] Accidental Death and Dismemberment Principal Sum Amount or the Table of Losses, if **your** [or **your covered dependent**] loss is sustained while **you** [or **your covered dependent**] were a passenger in a common carrier that is licensed to transport people.

For the purposes of this benefit, the term “common carrier” means airplanes, ships, trains, subways, buses, taxis or trolleys.]

[This provision is not applicable to **your covered dependents.**]

Repatriation Benefit

If an accidental death benefit is payable for loss of **your** [or **your covered dependent's**] life and death occurs at least 100 miles away from **your** [or **your covered dependent's**] permanent place of residence, a maximum benefit not to exceed [\$2,000] or the actual expense incurred, will be paid for customary and reasonable expenses for preparation and transportation of **your** [or **your covered dependent's**] body to the place of burial or cremation.

[This provision is not applicable to **your covered dependents.**]

Seat Belt Benefit

If **you** [or **your covered dependent**] die as the result of an automobile accident which occurs while **you** [or **your covered dependent**] are driving or riding in an automobile, **we** will pay an additional benefit equal to the lesser of [10%] of Your [or **your dependent**] Accidental Death and Dismemberment Principal Sum Amount or [\$10,000], if all of the following conditions are satisfied:

1. the seat belt was in actual use and was properly fastened at the time of the accident; and
 2. **you** [or **your covered dependent**] were driving or riding in an automobile driven by a licensed driver who was neither intoxicated nor under the influence of drugs at the time of the accident. Intoxication and being under the influence of drugs shall be determined as defined by the law of the jurisdiction in which the accident occurred; and
 3. the seat belt is certified in the official report of the accident, or by the investigating officer. A copy of the report must be submitted with the claim.
-

[Accidental Death and Dismemberment]

"Automobile" means a validly registered four-wheel passenger car, station wagon, jeep, pick-up truck or van-type vehicle. Legal State inspection is also required, if applicable.

"Seat belt" means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. "Seat belt" will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. "Seat belt" does not mean a shoulder restraint alone.

[This provision is not applicable to **your covered dependents.**]

Exclusions

A loss that is directly or indirectly a result of one or more of the following is not a Covered Loss even though it was caused by an accidental bodily **injury**:

1. bodily or mental infirmity or disease of any kind, or an infection (unless due to an accidental cut or wound); or
2. medical or surgical **treatment**, except where it is both: (a) **treatment** of an **injury** that meets the tests of a Covered Loss; and (b) **treatment** performed within 90 days after the **injury**; or
3. **your** [or **your covered dependent's**] participation in a war or an act of war, declared or undeclared; or
4. **your** [or **your covered dependent's**] service in the armed forces of any country or international authority for a period longer than 15 days; or
5. **your** [or **your covered dependent's**] unlawful participation in a riot, rebellion, or insurrection; or
6. **your** [or **your covered dependent's**] attempting to commit, or committing, an assault or felony; or
7. an intentionally self-inflicted **injury** or **illness** while sane or insane; or
8. suicide or attempted suicide whether sane or insane; or
9. riding in or descending from any kind of aircraft:
 - a. as a passenger on an aircraft operated by or for the armed forces; or
 - b. as a pilot or crewmember. (A crew member is anyone who has duties at any time on the flight, involving either the flight or the aircraft); or
 - c. as a participant in aviation training (student or instructor); or
 - d. as a participant in a sporting event or hobby; or]
10. **your** [or **your covered dependent's**] intoxication, as defined under the laws of the jurisdiction in which **your** [or **your covered dependent's**] Covered Loss occurred, except in the case of a narcotic that was administered or consumed on the advice of a **physician**]; or [
11. the voluntary taking of any kind of gas, except during the course of employment; the voluntary taking of any poison except in the case of accidental food poisoning]; or [

Life Insurance

[Accidental Death and Dismemberment]

12. participating in any hazardous activity such as: Scuba Diving, Bungee Jumping, Skydiving, Hang Gliding, Ballooning, Drag Racing, Competitive Racing, Aerial Hunting, Aerial Skiing, and Parachuting]; or [
 13. work or service in a country that is included or has been included in the past six months on the International Travel Warning list that is issued by the U.S. Department of State (www.travel.state.gov).]
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Notice

Written notice of claim should be given to **us** as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date of loss or as soon as reasonably possible.

Forms

When **we** receive notice of the claim, **we** will provide a claim form for filing a proof of loss. The form will be supplied to the claimant within 15 days of the day **we** receive notice of the claim.

If **we** do not provide a claim form within this 15-day period, the claimant may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character and extent of the loss.

Proof of Loss

Proof of loss must be sent to **us** within 90 days after the date of loss. A certified copy of a death certificate or other information **we** request must be given to **us** as proof of death.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of loss or as soon as reasonably possible.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve the proof of loss, **we** will pay any benefits **we** owe under the **policy**.

Payment of Claims

A claim for loss of **your** life will be paid according to the Beneficiary provision. Claim payments for all other benefits are payable to **you**.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **we** receive written proof of loss; or
2. after 3 years from the time the claimant was required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** or the claimant if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** or the claimant does not agree with the reasons given, **you** or the claimant may request a reconsideration of that claim.

To do so, **you** or the claimant should write to **us** within [60 days] after **you** or the claimant receives the notice of denial. **You** or the claimant should say why **you** or the claimant believe the claim denial was not proper including any appropriate data, questions or comments. Unless **we** request additional material, **you** or the claimant will be advised of **our** decision within [60 days] after **we** receive the letter for you or the claimant.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** or **your beneficiary** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Retiree Life Insurance

Schedule of Benefits

Eligible Class [Class A] – [All Employees]

Coverage Effective Date [11/01/2010]

Plan Date [11/01/2010]

Your Premium Contribution You are [not] required to contribute towards the cost of **your coverage**.

Your Life Insurance Amount [\$10,000] [[50%] of **your Pre-retirement Life Insurance Amount** [to a maximum of [\$25,000]]].

[Automatically reduces [10%] each year to a minimum of [\$500].]

[Automatically reduces according to the following Reduction Schedule:

<u>Attainment of Age</u>	<u>Reduces To</u>
[65]	[[50%] of your Pre-retirement Life Insurance Amount [\$10,000]
[66]	[[45%] of your Pre-retirement Life Insurance Amount [\$7500]
[67]	[[40%] of your Pre-retirement Life Insurance Amount [\$5000]
[68]	[[35%] of your Pre-retirement Life Insurance Amount [\$2000]
[69]	[[30%] of your Pre-retirement Life Insurance Amount [\$1000]
[70]	[[25%] of your Pre-retirement Life Insurance Amount [\$500]]

Beneficiary

The person designated by **you** to receive the proceeds of **your coverage** upon **your** death.

Pre-retirement Life Insurance Amount

Your Base Life Insurance Amount in effect on the date immediately preceding the date **you** retire.

Effective Date of your Life Coverage

Your coverage will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the day after **you** retire from employment, if:

1. **you** were **actively at work** on the day of **your** retirement; and
2. **you** enroll on or before that date or within 31 days after **your** Eligibility Date.

Eligibility Requirement

You will be eligible for **coverage** on the date **you** enter the **eligible class**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must have been an **active employee** prior to retirement to be eligible.

Enrollment Requirement

You are required to enroll for **your coverage** to become effective.

Termination of your Life Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment;

You will not be eligible to re-enroll for Retiree Life Insurance if **you** voluntarily terminate coverage or coverage terminates because **your** required premium contribution is not paid when due.

Death Benefit

If **you** die while **coverage** is effective under the **policy**, **we** will pay a death benefit to the **beneficiary** upon receipt of proof of death acceptable to **us**. This death benefit will be the amount of life insurance in force at the time of death.

Beneficiary

[Subject to the Assignment provision,] **you** have the right to name or change **your beneficiary**. Unless **we** receive (or **your covered employer** receives) a written and signed **beneficiary** designation or if **your** designated **beneficiary** is deceased at the time of **your** death, **your beneficiary** will be determined based on the following order:

1. **your** spouse, if living,
2. **your** children, if living, equally, or
3. **your** estate.

[Assignment

You may assign **your** rights to **your** life insurance provided that:

1. the assignment is made in writing on a form acceptable to **us**; and
2. **we** receive and register the assignment.

We are not responsible for the validity of the assignment.]

[Exclusion

Benefits will not be payable if **your** death is caused by or results from suicide, whether sane or insane, within two years from the date **your coverage** becomes effective.]

Conversion Privilege

When the Conversion Privilege Applies.

1. **You** are entitled to convert **your coverage** to an individual life insurance policy if **coverage** or any portion of it terminates due to:
 - a. reduction in benefits; or
 - b. loss of eligibility.

You are entitled to convert any amount up to the amount that terminated.

2. **You** are also entitled to convert **your coverage** provided **you** have been continuously insured under the **policy** or any policy it replaced for at least [5 years] prior to termination.
 - a. **You** are entitled to convert to an individual life insurance policy if **coverage** terminates due to:
 - i. termination of the **policy**; or
 - ii. amendment of the **policy** to terminate.
 - b. **You** can convert up to the lesser of:
 - i. [\$10,000]; or
 - ii. the amount of life insurance that terminates. This amount will be reduced by any new life insurance for which **you** become eligible under any other group policy within 31 days of termination of **coverage** under the **policy**.

Type of Conversion Policy Available. The conversion policy will be one of the individual life insurance policies, other than term insurance, then offered by **us**. The conversion policy will not include Waiver of Premium, Accidental Death and Dismemberment Benefits and Accelerated Death Benefits. It will be issued without evidence of insurability.

Effecting a Conversion: The conversion policy will become effective at the end of the 31-day conversion period after the life insurance terminates. To convert, **you** must submit the following information during that conversion period:

1. a written application; and
2. the first premium payment.

Notice of Right to Convert. **Your covered employer** will deliver a notice at least 15 days prior to the end of the conversion period. If **you** do not receive at least 15 days notice, **we** will extend the conversion period so that **you** will be given at least 15 days to decide whether to convert the **coverage**. This additional period will not extend beyond 60 days after the end of the 31-day conversion period. This extension does not continue life insurance **coverage** beyond the 31-day conversion period.

The premium for the conversion policy will be at the customary rate for:

1. that policy and that amount of insurance; and
2. the class of risk; and
3. the age on the individual policy's effective date.

Re-employment After Conversion. In order to obtain **coverage** again under the **policy** after a conversion policy has been issued, **you** must either: (a) surrender the conversion policy without claim; or (b) submit **evidence of insurability** to us.

Death Benefit. If **you** die during the 31-day conversion period, the amount of the death benefit will be the maximum amount of life insurance that could have been converted.

Notice

Written notice of claim should be given to **us** as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date of death or as soon as reasonably possible.

Forms

When **we** receive notice of the claim, **we** will provide a claim form for filing a proof of loss. The form will be supplied to the claimant within 15 days of the day **we** receive notice of the claim.

If **we** do not provide a claim form within this 15-day period, the claimant may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character and extent of the loss.

Proof of Loss

Proof of loss must be sent to **us** within 90 days after the date of death. A certified copy of a death certificate or other information **we** request must be given to **us** as proof of death.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of loss or as soon as reasonably possible.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve the proof of loss, **we** will pay any benefits **we** owe under the **policy**.

Payment of Claims

A claim for loss of **your** life will be paid according to the Beneficiary provision.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **we** receive written proof of loss; or
2. after 3 years from the time the claimant was required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify the claimant if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If the claimant does not agree with the reasons given, the claimant may request a reconsideration of that claim.

To do so, the claimant should write to **us** within [60 days] after receiving the notice of denial. The claimant should say why he or she believes the claim denial was not proper and should include any appropriate data, questions or comments. Unless **we** request additional material, the claimant will be advised of **our** decision within [60 days] after **we** receive the claimant's letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **your beneficiary** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Voluntary Life Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[11/01/2010]
Plan Effective Date	[11/01/2010]
Open Enrollment Period	[Not Available][October 1 – October 31.] [If you are already enrolled and age [60] or under, an increase of [\$10,000] is available to you up to the Guarantee Issue Amount. Amounts over [[\$10,000] or] the Guarantee Issue Amount will be subject to Evidence of Insurability.]
Work Hours Required for Eligibility	You regularly scheduled work hours must be at least [30] hours per week.
Waiting Period	For your coverage: [90] [days] [months] [For your dependent coverage: [90] [days] [months]] [Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.] [There will be no waiting period for employees who are actively at work and are part of the initial enrollment.]
Your Premium Contribution	You are required to pay the entire cost of coverage .
Voluntary Life Insurance Amount	Employee: [[\$50,000] [not to exceed [5] times your annual earnings .] [Cannot exceed the lesser of [6] times your annual earnings or [\$750,000] when combined with your Base Life Insurance amount.]] [Increments of [\$10,000], up to [\$500,000][.] [, not to exceed [5] times your annual earnings .] [Cannot exceed the lesser of [6] times your annual earnings or [\$750,000] when combined with your Base Life Insurance Amount.]] [Up to [5] times your annual earnings [, rounded to the [next higher] [next lower] [nearest] [\$1,000]] to a maximum of [\$500,000]. [Cannot exceed the lesser of [6] times your annual earnings or [\$750,000] when combined with your Base Life Insurance Amount.]] [Choice of: [\$10,000] [\$25,000] [\$50,000]

[\$750,000] when combined with **your** Base Accidental Death and Dismemberment Principal Sum Amount.]]

[Choice of: [\$10,000]
[\$25,000]
[\$50,000]
[\$75,000]
[\$100,000]

[not to exceed [5] times **your annual earnings**.] [Cannot exceed the lesser of [6] times **your annual earnings** or [\$750,000] when combined with **your** Base Accidental Death and Dismemberment Principal Sum Amount.]]

[Spouse: [\$50,000] [In increments of [\$5,000,] up to [\$250,000]] [not to exceed [50%] of **your** approved Voluntary Accidental Death and Dismemberment Principal Sum Amount][, rounded to the [next higher] [nearest] [next lower] [\$1,000]].

[Child – [6] months to [19] years: [\$2,000] [In increments of [\$1,000], up to [\$10,000]

Infant Child – [14] days to [6] months: [\$500] [[10%] of Child Voluntary Accidental Death and Dismemberment Principal Sum Amount]]

[Voluntary Accidental Death and Dismemberment Principal Sum Amounts automatically reduce according to the following Reduction Schedule:

<u>Attainment of Age</u>	<u>Reduces To</u>
[65]	[92%] of Scheduled Benefit [\$40,000]
[66]	[84%] of Scheduled Benefit [\$30,000]
[67]	[76%] of Scheduled Benefit [\$20,000]
[68]	[68%] of Scheduled Benefit [\$10,000]
[69]	[60%] of Scheduled Benefit [\$5,000]
[70]	[\$0]

“Scheduled Benefit” means the amount that would otherwise be payable in the absence of the Reduction Schedule.]]

[Voluntary Accidental Death and Dismemberment Additional Benefits

Air Bag Benefit - Included
Brain Damage Benefit – [Included][Not Included]
Coma Benefit – [Included][Not Included]
Common Accident Benefit – [Included][Not Included]
Education Benefit – [Included][Not Included]
[Exposure and Disappearance Benefit – [Included][Not Included]]

Voluntary Life Insurance

Schedule of Benefits

Felonious Assault Benefit – [Included][Not Included]
 [Home Alteration and Vehicle Modification Benefit – [Included][Not Included]]
 Public Transportation Benefit - [Included] [Not Included]
 Repatriation Benefit - Included
 Seat Belt Benefit - Included

[Guarantee Issue Amount

[Employee Benefit
 Age [60] or under: [\$100,000]
 Age [61] to [69]: [50%] of the employee Guarantee Issue Amount listed above
 Age [70] and over: \$0

[Spouse Benefit
 Age [60] or under: [\$50,000]
 Age [61] to [69]: [50%] of the spouse Guarantee Issue Amount listed above
 Age [70] and over: \$0]

[[Employee Benefit [\$150,000]
 [Spouse Benefit] [\$30,000]]

Amounts in excess of the Guarantee Issue Amount will require **our** approval of **evidence of insurability.**]

Dependent Coverage

[Not] Included

[Dependent Student Age Limit

[23] years]

Accelerated Benefit

Included

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence

[Temporary Layoff – [Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.][Up to [3] months after **your** last day of **active work.**]]

Injury or Illness – [Up to [2] months after **your** last day of **active work.**] [The lesser of [2] months after **your** last day of **active work** or attainment of age 65.] [To age 65.] (up to 12 weeks for a leave under the Family and Medical Leave Act.)

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Refer to Conversion Privilege for continuation beyond what is specified above.

Annual Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions prior to the date of **your** death or the date **your** disability began, but excluding commissions, bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including commissions averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including commissions and bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions including bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date of **your** death or the date **your** disability began, but excluding commissions, overtime pay and other extra compensation.]

[**Your** gross earnings from the **covered employer** as shown on **your** W-2 from the **covered employer** for the preceding **calendar year**.]

[For 1099 income, **your** earnings from the **covered employer** as reported on the 1099-Misc of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a 1099-Misc for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.]

For partners, **your** average earnings from the partnership calculated from the "net earnings from self-employment" section on Schedule K-1 of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a Schedule K-1 for the preceding **calendar year** or tax year, **we** will annualize **your** earnings using the number of months worked.

For sole proprietors, **your** annual net profit as shown on **your** Form 1040-C for the preceding **calendar year** or tax year excluding depreciation and expenses for business use of **your** home. If **you** did not file a Form 1040-C for the preceding **calendar year** or tax year, **we** will annualize **your** earnings using the number of months worked.

For shareholders of an S Corporation, **your** average earnings as an insured shareholder based on:

1. the "Wages, Tips and Other Compensation" of **your** Form W-2 and including compensation deferral reported on **your** Form W-2 received from the **covered employer**:
 - a. for the **calendar year** immediately prior to the date of **your** death or the date **your** disability began; or

- b. for the period of employment with the **covered employer** if **you** did not receive a W-2 Form prior to the date of **your** death or the date **your** disability began; and
2. **your** ordinary income or loss from trade or business activities from Schedule K-1 of **your** federal income tax return from the **covered employer** for the year immediately prior to the date of **your** death or the date **your** disability began.

If **you** have not been a shareholder for the year for which the most recent S Corporation federal income tax return was filed, **your** earnings will be based on the period of actual employment during which **you** were a shareholder. **Annual earnings** does not include income received from sources other than as a shareholder of the **covered employer**.

Beneficiary

The person designated by **you** to receive the proceeds of **your** voluntary life insurance upon **your** death.

Child

Your natural, adopted, foster, or step-child.

An "adopted child" is any child under the charge, care, and control of **you** whom **you** have filed a petition to adopt. An adopted child will be subject to the same conditions as a natural child.

A "step-child" is a child of **your** spouse who lives within the same household as **you** or is financially dependent upon **you**.

[Covered Dependent

A **dependent** with **coverage**]

[Dependent

Your:

1. spouse;
2. unmarried **children** from [14 days] to age [19] [who are primarily dependent upon **you** for support and maintenance;
3. **child** after their [19th] birthday if we receive written proof, not more frequently than every three months, that the **child** is:
 - a. a full-time student at an accredited school;
 - b. primarily dependent upon **you** for support and maintenance;
 - c. not married; and
 - d. under the Dependent Student Age Limit shown in the Schedule of Benefits.;
- and
4. **child** after their [19th] birthday if the **child** has been continuously insured and is:
 - a. incapable of self-sustaining employment because of mental or physical incapacity and became incapable prior to [attaining the Dependent Student Age Limit] [age [19]];
 - b. primarily dependent upon **you** for support and maintenance;

- and
c. not married.

In order to continue the **child's coverage**, **you** must submit to **us** proof of the **child's** incapacity.

These persons are excluded as **dependents**:

1. **your** former spouse, if either **you** or **your** spouse has obtained a decree of divorce or legal separation (in a state where this is recognized);
2. a person who is on active duty in the military service of any country;
3. a person who is covered under the **policy** as an employee. If both **you** and **your** spouse are eligible employees, **your children** will be covered as **dependents** of either **you** or **your** spouse, but not both.]

[Domestic Partner

Your partner who:

1. is not related to **you** by blood closer than permitted under applicable state marriage laws;
2. is not married and does not have any other **domestic partners**;
3. is at least eighteen (18) years of age and has the capacity to enter into a contract;
4. shares a residence with **you**;
5. is jointly responsible with **you** for the necessities of life and can produce documentation of at least three of the following as evidence of joint responsibility:
 - a. joint mortgage or joint tenancy on a residential lease;
 - b. joint bank account;
 - c. joint liabilities (e.g. credit cards or car loans);
 - d. joint ownership of significant property (e.g. cars, land, etc.)
 - e. naming of each other as primary beneficiary in wills or life insurance policies;
 - f. written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
 - g. commitment to a long term relationship with the intention of remaining together indefinitely.

All references to spouse include **domestic partner**.]

Evidence of Insurability

A statement of **your** [or **your dependent's**] medical history and evidence of good health, which **we** will use to determine if **you** [or **your dependent**] are approved for **coverage**.

Evidence of insurability will be provided at **your** expense.

Illness

Your medically determinable sickness, disease or pregnancy.

[Disability resulting from **illness** must begin while **you** are covered under the

policy.]

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Injury which occurs before **you** are covered under the **policy** will be treated as an **illness**. [Disability must begin while **you** are covered under the **policy**.]

Late Enrollment

You enroll for **coverage** more than 31 days after the date **you** initially become eligible for **coverage**.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**, including any increase in **coverage** due to an increase in **annual earnings** of 10% or more.

Physician

A person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery and is operating within the scope of his or her license; or
2. is legally qualified as a medical practitioner and required to be recognized by the insurance laws of the governing jurisdiction.

A **physician** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

Total Disability

You are unable to perform the duties of any occupation for which **you** are or become qualified by education, training or experience because of **injury** or **illness**.

Treatment

Includes:

1. consulting with or receiving advice from a **physician**;
 2. receiving care or services from a **physician** or from other medical professionals a **physician** recommends **you** see;
 3. being prescribed medicines, whether or not **you** choose to take them;
 4. refilling prescribed medicines; or
 5. receiving diagnostic measures or services.
-

Voluntary Life Coverage – for you

Effective Date of your Voluntary Life Coverage

If **you** are under the age of 70, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. the Evidence of Insurability Requirement, if applicable; and
5. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage** or any **new coverage**, if **you** enroll on or before that date or within 31 days after **your** eligibility date; or
2. the date **we** approve **your** evidence of insurability, if applicable.

[If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the date **you** meet the Evidence of Insurability Requirement.]

Increases or decreases in **your** Coverage Amount due to changes in class or earnings will become effective on the date **you** begin **active work** in the new class or at the new earnings level.

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a **late enrollment**, **you** must satisfy the Evidence of Insurability Requirement for **your coverage** to become effective.]

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a **late enrollment**:

1. **you** must satisfy the Evidence of Insurability Requirement for **your coverage** to become effective; and
2. **you** can only enroll during the Open Enrollment Period shown in the Schedule of Benefits.]

[If **you** acquire a new **dependent** due to marriage, birth, adoption or placement for adoption, **you** may add or increase **your coverage** up to the Guarantee Issue Amount shown in the Schedule of Benefits provided that **you** do so within 31 days of acquiring **your new dependent**. Any **coverage** over the Guarantee Issue Amount will be subject to the Evidence of Insurability Requirement.]

Evidence of Insurability Requirement

When **we** request **evidence of insurability** as a condition for **your coverage** or for any **new coverage**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as a part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. for **late enrollment**; or
2. if **you** voluntarily terminated **your coverage** and are re-enrolling; or
3. if **you** apply for amounts in excess of the Guarantee Issue Amount shown in the Schedule of Benefits; or
4. for amounts **you** request to increase **your** Voluntary Life Insurance Benefits[.]; or
5. if **you** are age [60] or under and applying for an increase greater than [\$10,000] to **your** Voluntary Life Insurance Benefits during the Open Enrollment Period; or
6. for an increase in **coverage** due to an increase in annual earnings of 10% or more.]

If approved, **your coverage** or **new coverage** will become effective on the date **we** approve **your** application and **you** have paid the premiums due.

Termination of your Voluntary Life Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. the date **you** are no longer **actively at work**, except as provided under [the Continuation of Coverage during Injury, Illness, [Temporary Layoff,] or other Leave of Absence] [and] [the Portability provision].

Voluntary Life Coverage – for you

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a continuation of **coverage** under the **policy** due to a **total disability** that began prior to the date of the termination.

Continuation of Coverage during Injury, Illness, [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness**, or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work** and is subject to the reductions in benefits of the **eligible class**.

Your normal vacation time or any period of disability is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will apply any prior period of work with **your covered employer** toward the **waiting period**. The following conditions will apply:

1. **your** return to **active work** must occur within [12] months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. the maximum benefits reinstated will not exceed the Guarantee Issue Amount shown in the Schedule of Benefits. Any amounts over the Guarantee Issue Amount will require **evidence of insurability**; and
4. [if **you** elected to port **your coverage** under the Portability Benefit or] if a life insurance conversion policy was issued, **you** must surrender the [portability coverage or] conversion policy without claim.

All other **policy** provisions apply.

[Continuation of Coverage During Total Disability

QUALIFYING FOR CONTINUATION OF COVERAGE

Your coverage will continue during a period of **total disability** if:

1. **your total disability** begins while **your coverage** is effective and **you** are under age [60]; and
2. **your total disability** has been continuous during a [9] month waiting period; and
3. **you** or a person acting on **your** behalf notifies **us** of **your total**

Voluntary Life Coverage – for you

- disability** within [12] months after the date **your total disability** begins; and
4. **we** approve **your** claim for **total disability**.

If **you** die during the [9] month waiting period, and **you** would have otherwise qualified for continuation, the waiting period will be considered satisfied.

If **you** are over age [60] when **your total disability** begins, **you** are not entitled to continue **your coverage** under this provision, and **coverage** will terminate as shown in Termination of your Voluntary Life Coverage.

[This provision is not applicable to **your dependents**.]

AMOUNT OF VOLUNTARY LIFE INSURANCE CONTINUED

The amount of **your** voluntary life insurance that will be continued during **your total disability** is the amount of **your** voluntary life insurance on **your** last day of **active work**. This amount will continue to be subject to the scheduled reductions and termination shown in the Schedule of Benefits. This amount will be further reduced by the amount of any individual policy issued to **you** pursuant to the Conversion Privilege and any amount paid under the Accelerated Benefit provision.

NOTICE AND PROOF OF TOTAL DISABILITY

You or a person acting on **your** behalf must provide **us** with written notice and the first proof of **total disability** at **our home office** within [12] months after **your total disability** begins. If **we** request written proof of **total disability** after the first proof, **you** must provide **us** with the required written proof within [3] months after the date of request.

You must give **us** proof of **total disability** as often as **we** deem reasonably necessary. After the first two years of **total disability**, **we** will not require proof more than once a year. As part of this proof, **we**, at **our** expense, may require that **you** get an examination. This examination must be made by a **physician** approved by **us**.

If it is not possible to give **us** notice or proof of **your total disability** within these time limits, **you** must give **us** the proof as soon as reasonably possible. The notice may not be given more than [3] months later than the time that either the notice or proof is required.

If **you** die before **you** first submit proof, the proof must be submitted with the proof of death.

TERMINATION OF YOUR CONTINUED VOLUNTARY LIFE INSURANCE

Your continued voluntary life insurance will terminate on the earliest of the following dates:

1. the date **you** are no longer totally disabled; or
2. the date **you** fail to give **us** written proof of continued **total disability** within the time required; or
3. the date **you** attain age [65].

If **you** continued voluntary life insurance terminates (unless **you** become a **covered person** again), **you** may exercise the Conversion Privilege. This privilege will apply as if **you** were no longer in an **eligible class** on the date **your** continued voluntary life insurance terminated.

WAIVER OF PREMIUM

Premium will not be payable during any period that **you** are totally disabled and **your total disability** has been approved by **us**.]

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group voluntary life insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy** through the date **your** disability began or **your** date of death.

[If **you** are not **actively at work** due to **[injury]**, **[or]** **[illness]**, **[or]** **[leave of absence]**, **[or]** **[temporary layoff]** on the effective date of the **policy**, **we** will provide Continuity of Coverage if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy**. **We** will provide limited coverage under this Continuity of Coverage provision.

Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your coverage** is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy**.

We will provide **coverage** according to the terms of the Prior Plan, less any benefits for which the Prior Plan is liable.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will not begin before **you** return to **active work**.]]

[Voluntary Life Coverage – for your Dependents]

Effective Date of your Dependent Voluntary Life Coverage

Your **dependent coverage** or any **new coverage** with respect to **dependent coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement for your Dependent Voluntary Life Coverage;
2. the Enrollment Requirement for your Dependent Voluntary Life Coverage;
3. the Evidence of Insurability Requirement for your Dependent Voluntary Life Coverage, if applicable; and
4. **you** have paid the first premium for **your dependent** when due.

When **you** have satisfied the above requirements, **your dependent** will be covered at 12:00 a.m. on the later of:

1. the date **your dependent** is eligible for **coverage**, if **you** enroll for **dependent coverage** within 31 days after your **dependent's** eligibility date; or
2. the date **we** approve **your dependent's evidence of insurability**, if applicable.

The effective date will be deferred for a **dependent** if they are in a medical care facility, or are in a period of limited activity due to an **illness or injury**, when the **coverage** is due to become effective. In this case, the **coverage** will become effective on the first day of the month following the date the **dependent** has been free from confinement for 7 consecutive days and/or returned to normal activities.

Eligibility Requirement for your Dependent Voluntary Life Coverage

If **you** enroll **your dependents** within 31 days after **your dependents** become eligible, **your dependent coverage** will become effective on the date **you** have satisfied the following:

1. **your coverage** is in effect; and
2. **your eligible class** provides for **dependent coverage**; and
3. a person meets the definition of **your dependent**; and
4. **you** have completed the **waiting period** for **dependent coverage**.

[If **you** enroll **your dependent** more than 31 days after **your dependent** becomes eligible, **your dependent coverage** will become effective on the later of:

1. the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits; or
2. the date **your dependent** meets the Evidence of Insurability Requirement.]

[If **you** enroll **your dependent** more than 31 days after **your dependent** becomes eligible, **your dependent coverage** will become effective on the date **your dependent** meets the Evidence of Insurability Requirement.]

Enrollment Requirement for your Dependent Voluntary Life Coverage

You are required to enroll each of **your dependents** for **coverage** to become effective.

[If **you** submit a **late enrollment** for a **dependent**, **you** will be required to

[Voluntary Life Coverage – for your Dependents]

submit **evidence of insurability** before the **coverage** on that **dependent** can become effective.]

[If **you** submit a **late enrollment** for a **dependent**:

1. **you** will be required to submit **evidence of insurability** before the **coverage** on that **dependent** can become effective; and
2. **you** can enroll **your dependent** only during the Open Enrollment Period shown in the Schedule of Benefits.]

Evidence of Insurability Requirement for your Dependent Voluntary Life Coverage

When **we** request **evidence of insurability** as a condition for **coverage** or for any **new coverage** on **your dependent**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. if **you** are enrolling for **dependent coverage** more than 31 days after the date **your dependents** are eligible for **coverage**; or
2. if **you** voluntarily terminated **your dependent coverage** and are re-enrolling; or
3. [if **you** apply for **dependent** amounts in excess of the Guarantee Issue Amount shown in the Schedule of Benefits; or]
4. for amounts **you** request to increase **your dependent coverage** amounts.

If approved, **your coverage** will become effective on the date **we** approve **your** application and **you** have paid the premium due.

Effective Date of Changes in your Dependent Voluntary Life Coverage Amount

Increases or decreases in **your dependent** voluntary life insurance amount will become effective as follows:

Benefit Change due to Change in Age: The change will become effective at 12:00 a.m. on the date of the change in age.

Benefit Change due to Change in **Your** Voluntary Life Insurance Amount: The change will become effective at 12:00 a.m. on the same date as the change in **your coverage**.

The effective date of an increase in **your dependent coverage** amount will be deferred for a **dependent** if they are in a medical care facility, or are in a period of limited activity due to an **illness** or **injury**, when the **new coverage** is due to become effective. In this case, the **new coverage** will become effective on the first day of the month following the date the **dependent** has been free from confinement for [7] consecutive days and/or returned to normal activities.

[Voluntary Life Coverage – for your Dependents]

Termination of your Dependent Voluntary Life Coverage

Coverage on your dependents will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date **your coverage** terminates; or
 2. the date **your dependent coverage** is discontinued under the **policy**; or
 3. for a particular **dependent**, the date that the **dependent** is no longer an eligible **dependent**, or
 4. the last day for which **you** make a required premium payment.
-

Voluntary Life Insurance

Voluntary Life Benefit

Death Benefit

If **you** [or **your covered dependent**] die while **coverage** is effective under the **policy**, **we** will pay a death benefit to the **beneficiary** upon receipt of proof of death acceptable to **us**. This death benefit will be the amount of voluntary life insurance in force at the time of death.

Beneficiary

[Subject to the Assignment provision,] **you** have the right to name or change **your beneficiary**. Unless **we** receive (or **your covered employer** receives) a written and signed **beneficiary** designation or if **your** designated **beneficiary** is deceased at the time of **your** death, **your beneficiary** will be determined based on the following order:

1. **your** spouse, if living,
2. **your children**, if living, equally, or
3. **your** estate.

[The **beneficiary** for **your covered dependents** will be **you**.]

[Assignment

You may assign **your** rights to **your** voluntary life insurance provided that:

1. the assignment is made in writing on a form acceptable to **us**; and
2. **we** receive and register the assignment.

We are not responsible for the validity of the assignment. [**Dependent coverage** is not assignable.]]

[Exclusion

Benefits will not be payable if **your** death [or the death of **your covered dependents**] is caused by or results from suicide, whether sane or insane, within two years from the date **your coverage** [or **your dependents coverage**] becomes effective.]

Portability Benefit

When Portability Applies:

Portability is **your** right to continue insurance for **yourself** [and **your covered dependents**] at the time **your** voluntary life **coverage** ends. **Coverage** continued under this provision is subject to all other provisions and limitations of the **policy** unless specifically noted otherwise.

You [and **your covered dependents**] may continue **coverage** provided that:

1. **you** are under the age of [60], and
2. **you** have been continuously covered under the **policy** for at least [12] months prior to the date **coverage** terminates; and
3. **coverage** ends for any reason other than:
 - a. termination of the **policy** by the **covered employer**;
 - b. **your** retirement;
 - c. termination due to **your** disability[.] [or death;
 - d. termination due to divorce or legal separation where recognized by state law.]

[You must elect portability to have portable coverage for your covered dependents.]

Amount of Insurance:

You [and **your covered dependents**] may continue **coverage** up to the amount terminated. Waiver of Premium, Accidental Death and Dismemberment Benefits and Accelerated Death Benefits are not available.

Notice of Portability Rights:

Your covered employer will deliver a notice at least 15 days prior to the end of the portability period.

You must submit an application [and pay the required premium] to **us** within 31 days after **coverage** ends. If **you** do not elect this Portability Benefit within 31 days after **coverage** ends, **you** may not elect to port **coverage** at a later date.

Premium:

The premium for this **coverage** will be based on the rate in force for the **policy**.

Limitations and Termination:

Coverage under this Portability Benefit will terminate on the earliest of:

1. the date the **covered employer** cancels **coverage** for all members of the class **you** were covered under when **your coverage** terminated;
2. the day after the end of the period for which premium is paid;
3. **your** attainment of age [65];
4. the date the **policy** terminates;
5. the date **you** re-enroll or are reinstated under the **policy** as an **active employee**.

Coverage will reduce in accordance with the Age Reduction provision in the Schedule of Benefits. Conversion Privilege will apply if **coverage** ends due to:

1. reaching termination age;
2. termination of **coverage** for all members of the class **you** were covered under when **your coverage** terminated;
3. termination of the **policy** by the **covered employer**.

If **coverage** terminates due to nonpayment of premium, the Conversion Privilege will not apply.

Conversion Privilege

When the Conversion Privilege Applies.

1. **You [or your covered dependents]** are entitled to convert **your coverage [or your dependent coverage]** to an individual life insurance policy if **coverage** or any portion of it terminates due to:
 - a. termination of **your** employment; or
 - b. reduction in benefits; or
 - c. loss of eligibility[.] [;or
 - d. loss of eligibility as a **dependent**.]

You [or your covered dependents] are entitled to convert any amount up to the amount that terminated.

2. **You [or your covered dependents]** are also entitled to convert **your coverage [or your dependent coverage]**, provided **you [or your covered dependents]** have been continuously insured under the **policy** or any policy it replaced for at least [5] years prior to termination.
 - a. **You [or your covered dependents]** are entitled to convert to an individual life insurance policy if **coverage** terminates due to:
 - i. termination of the **policy**; or
 - ii. amendment of the **policy** to terminate[.]; or
 - iii. amendment of the **policy** to remove **dependent** benefits].
 - b. **You [or your covered dependents]** can convert up to the lesser of:
 - i. [\$10,000]; or
 - ii. the amount of life insurance that terminates. This amount will be reduced by any new life insurance for which **you [or your covered dependents]** become eligible under any other group policy within 31 days of termination of **coverage** under the **policy**.

Type of Conversion Policy Available. The conversion policy will be one of the individual life insurance policies, other than term insurance, then offered by **us**. The conversion policy will not include Waiver of Premium, Accidental Death and Dismemberment Benefits and Accelerated Death Benefits. It will be issued without **evidence of insurability**.

Effecting a Conversion: The conversion policy will become effective at the end of the 31-day conversion period after the voluntary life insurance terminates. To convert, **you [or your covered dependent]** must submit the following information during that conversion period:

1. a written application; and
2. the first premium payment.

Notice of Right to Convert. **Your covered employer** will deliver a notice at

least 15 days prior to the end of the conversion period. If **you** do not receive at least 15 days notice, **we** will extend the conversion period so that **you** will be given at least 15 days to decide whether to convert the **coverage**. This additional period will not extend beyond 60 days after the end of the 31-day conversion period. This extension does not continue voluntary life insurance **coverage** beyond the 31-day conversion period.

The premium for the conversion policy will be at the customary rate for:

1. that policy and that amount of insurance; and
2. the class of risk; and
3. the age on the individual policy's effective date.

Re-employment After Conversion. In order to obtain **coverage** again under the **policy** after a conversion policy has been issued, **you** must either: (a) surrender the conversion policy without claim; or (b) submit **evidence of insurability** to **us**.

Death Benefit. If **you** [or **your covered dependent**] die during the 31-day conversion period, the amount of the death benefit will be the maximum amount of voluntary life insurance that could have been converted.

Voluntary Life Insurance

Accelerated Benefit - for Limited Life Expectancy

Important information about your Accelerated Benefit:

Payment of an Accelerated Benefit may be taxable. If you receive payment of an Accelerated Benefit, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplementary Security, Supplemental Security Income (SSI), and others. You should seek assistance from a personal tax advisor regarding taxes you may have to pay as the result of claiming an Accelerated Benefit.

Requirements

You will be entitled to accelerate **your** Death Benefit under the **policy**, if **you** have been diagnosed with a terminal condition, as certified by a **physician**, while insured under the **policy**.

To receive this benefit, **you** must:

1. make a written request on a form acceptable to **us**; and
2. submit medical evidence acceptable to **us** that **you** have a terminal condition.

At **our** expense, **we** have the right to ask for a medical examination in connection with a claim.

"Terminal condition" means that **you** are expected to have [12] months or less to live, as certified by a **physician**.

You will not be eligible for the Accelerated Benefit if **your** voluntary life insurance is scheduled to reduce or end as shown in the Schedule of Benefits within [24] months following the date **you** make application for the Accelerated Benefit.

Administrative Charge

At the time **you** receive **your** Accelerated Benefit, **we** will deduct [\$250] from the amount of **your** Accelerated Benefit as an administrative charge.

Amount payable

We will pay **you** up to the lesser of:

1. [50%] of **your** voluntary life insurance amount that is in force at the time of the request; or
2. [\$250,000].

You can choose to take less than [50%] of **your** voluntary life insurance amount, but **you** may receive an Accelerated Benefit only once in **your** lifetime. The minimum amount that **you** may choose to receive is [25%] of **your** voluntary life insurance amount.

To whom payable

The Accelerated Benefit is payable only to **you**.

Voluntary Life Insurance

Accelerated Benefit - for Limited Life Expectancy

Method and Timing of Payment

The Accelerated Benefit is payable in a lump sum. It will not be paid if **you** die before payment is made. At the time **we** pay **you** the Accelerated Benefit, **we** will provide **you** with a benefit payment notice informing **you** of the amount of **your** Accelerated Benefit, the amount of the administrative charge, and the amount of insurance remaining.

Effect on Voluntary Life Coverage

The amount of **your** voluntary life insurance will be reduced by:

1. any benefit paid to **you**; plus
2. the amount of the administrative charge.

Voluntary Life Conversion

If **your** voluntary life insurance terminates, **you** may convert **your** voluntary life insurance amount remaining after reduction of the Accelerated Benefit, subject to the provisions of the Conversion Privilege.

Reductions

If **you** are subject to an age reduction after payment of the Accelerated Benefit, the reduction will be applied to the original face amount. Upon death, the benefit payable will be the reduced benefit, minus the Accelerated Benefit payment.

If **your** voluntary life insurance benefit reduces, the amount of the Accelerated Benefit plus the corresponding death benefit will never exceed the amount that would have been paid had there not been an Accelerated Benefit.

If **you** recover and return to **active work**, **your** Voluntary Life Insurance Amount will remain reduced by the accelerated benefit approved by **us**.

Voluntary Life Insurance

[Voluntary Accidental Death & Dismemberment]

Effective Date of your [and your Dependent] Voluntary Accidental Death and Dismemberment Coverage

Your [and your dependent] voluntary accidental death and dismemberment coverage will become effective on the later of the following dates:

1. the date that **your** [and **your dependent**] voluntary life insurance becomes effective; or
2. the date that the **policy** is amended to include voluntary accidental death and dismemberment **coverage** for **your eligible class** [or for eligible **dependents**].

Termination of your [and your Dependents] Voluntary Accidental Death and Dismemberment Coverage

Your [and your dependent] voluntary accidental death and dismemberment coverage will terminate on the earliest of the following dates:

1. the date **your** [and **your dependent**] voluntary life insurance terminates; or
2. the date the **policy** is amended to terminate **your** [and **your dependent**] voluntary accidental death and dismemberment **coverage**; or
3. the date **your** [and **your dependent**] voluntary accidental death and dismemberment **coverage** terminates as shown in the Schedule of Benefits.

Benefit Payable

Benefits will be paid according to the following:

1. When **you** [or **your dependent**] have a Covered Loss, **we** will pay a benefit as shown in the Table of Losses.
2. The "Principal Sum Amount" is the amount shown in the Schedule of Benefits.
3. These benefits are payable in accordance with the Claims Provisions.

Covered Loss

A loss shown in the Table of Losses that meets all of the following conditions:

1. The Covered Loss results directly from an **injury** and must be independent of all other causes. This **injury** must be caused by an accident that occurs while **your** [or **your dependent**] **coverage** is effective.
2. The Covered Loss must not be excluded under Exclusions.
3. The Covered Loss, except for loss of life, must occur no more than 90 days after the date of the **injury**.

Table of Losses

IN THE EVENT OF LOSS OF:

THE BENEFIT WILL BE:

Life

The Principal Sum Amount

Hand, foot or eyesight:

1. any single loss:
2. more than one loss from any one accident:

One Half of the Principal Sum Amount

The Principal Sum Amount

[Voluntary Accidental Death & Dismemberment]

For the loss of a hand or foot, there must be actual severance at or above the wrist or ankle joint.

Loss of sight of an eye means the eye is totally and irreversibly blind.

IN THE EVENT OF LOSS
RESULTING IN:

THE BENEFIT WILL BE:

Quadriplegia

The Principal Sum Amount

Paraplegia

One Half of the Principal
Sum Amount

Hemiplegia

One Half of the Principal
Sum Amount

IN THE EVENT OF LOSS OF:

Use of Both Hands or Both
Legs

One Half of the Principal Sum Amount

Use of One Hand or One Leg

One Fourth of the Principal
Sum Amount

We will not pay a voluntary accidental death and dismemberment benefit for any paralysis caused by a stroke.

IN THE EVENT OF LOSS OF:

THE BENEFIT WILL BE:

Speech and Hearing

The Principal Sum Amount

Speech or Hearing

One Half of the Principal
Sum Amount

Hearing in One Ear

One Fourth of the Principal
Sum Amount

Loss must be determined by a **physician** to be permanent, complete and irreversible.

The Maximum Amount payable for all losses from any one accident will be the Principal Sum Amount.

Air Bag Benefit

If the benefit is payable under the Seat Belt Benefit and the automobile is equipped with a factory installed air bag system, an additional benefit will be paid of the lesser of [5%] of **your** [or **your dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or [\$5,000] if:

1. **you** [or **your covered dependent**] were positioned in a seat that is designed to be protected by an air bag; and
 2. the air bag inflated properly upon impact and is certified in the official accident report, or by the investigating officer. A copy of the report must be submitted with the claim.
-

[Voluntary Accidental Death & Dismemberment]

[This provision is not applicable to **your covered dependents.**]

[Brain Damage Benefit

If **you** [or **your covered dependent**] sustain an **injury** which, independent of all other causes, directly results in the traumatic brain injury causing brain damage, **we** will pay a benefit equal to the lesser of [5%] of **your** [or **your covered dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or [\$5000], if all of the following conditions are met:

1. the brain damage begins within 60 days of the **injury**; and
2. the brain damage continues for 12 consecutive months; and
3. a **physician** certifies the brain damage is permanent and irreversible at the end of the 12 consecutive

Payment of the Brain Damage Benefit plus any other benefits payable as a result of the same accident will not exceed the Voluntary Accidental Death and Dismemberment Principal Sum Amount the insured is eligible to receive.

“Brain Damage” means a traumatic brain injury which causes the complete inability to perform all of the Activities of Daily Living.

“Activities of Daily Living” means:

BATHING – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.

DRESSING – putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

TOILETING – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

TRANSFERRING – moving into and out of a bed, chair, or wheelchair.

MOBILITY – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.

CONTINENCE – the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

EATING – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table).]

A person is considered unable to perform an activity of daily living if the task cannot be performed safely without another person’s stand-by assistance or verbal cueing.

[This provision is not applicable to **your covered dependents.**]

[Coma Benefit

If **you** [or **your covered dependent**] sustain an **injury** which, independent of all other causes, directly results in a coma, **we** will pay a benefit equal to the lesser of [5%] of **your** [or **your covered dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or [\$5,000], if all of the following conditions are met:

[Voluntary Accidental Death & Dismemberment]

1. **You** [or **your covered dependent**] must remain in a coma for 31 continuous days; and
2. the onset of the coma must occur within 31 days of the accident.

Payment of the Coma Benefit plus any other benefits payable as a result of the same accident will not exceed the Accidental Death and Dismemberment Principal Sum Amount the insured is eligible to receive.

“Coma” means a profound stupor or state of complete and total unconsciousness, as the result of an accident.

[This provision is not applicable to **your covered dependents.**]

[Common Accident Benefit

If **you** and **your** covered spouse die within [3 months] from a Common Accident and are survived by one or more **dependent children**, we will increase **your** covered spouse’s Voluntary Accidental Death and Dismemberment Principal Sum Amount to 100% of Your Voluntary Accidental Death and Dismemberment Principal Sum Amount.

“Common Accident” means the same Covered Loss or separate Covered Loss that occur within the same 24 hour period.]

[Education Benefit

If an accidental death benefit is payable for loss of **your** [or **your covered dependent’s**] life, an additional benefit of [\$2,500] will be paid per academic term for a maximum of 8 payments to **your dependent** student. This benefit will be payable, subject to satisfactory proof, for each qualifying **dependent child** for post-secondary education expenses. [If both parents die as a result of the same accident, the maximum benefit payable is [\$2,500] per academic term for a maximum of 8 payments.]

“Student” means a **dependent child** who, on the date of **your** death:

1. is already enrolled full-time in an education program; or
2. is at a secondary school level but will enroll as a full-time student in a post-secondary education program within 365 days of **your** death.

“Post-secondary education” includes any accredited institution of higher learning beyond the 12th grade level. The **dependent child** must be a full-time student as defined by the institution.

If **your dependent child** satisfies the above requirements, any benefits payable will be paid to the person having primary responsibility for these expenses.

The Education Benefit will terminate for each **dependent** student on the earliest of the following dates:

1. the date the **dependent** student failed to furnish proof of full-time enrollment as required by **us**; or
2. the date the **dependent** student no longer qualifies as a **dependent child** for any reason except **your** death; or
3. the end of the maximum benefit period.

[Voluntary Accidental Death & Dismemberment]

[This provision is not applicable due to the death of **your dependents**.]

[Exposure and Disappearance Benefit

We will pay an exposure benefit when **you** [or **your covered dependent**] experience a loss which results from unavoidable exposure to the elements. The loss must be listed in the Table of Losses. The benefit is paid according to the applicable percentage listed in the Table of Losses.

If **you** [or **your covered dependent**] disappear as a result of a forced landing, stranding, sinking or wrecking of any conveyance in which **you** [or **your covered dependent**] are traveling, and **you** [or **your covered dependent**] are not found within one year of the accident, **you** [or **your covered dependent**] will be presumed to have died in the accident. The amount payable for disappearance will be **your** [or **your Dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount.

[This provision is not applicable to **your covered dependents**.]]

[Felonious Assault Benefit

We will pay an additional benefit equal to the lesser of [5%] of Your Accidental Death and Dismemberment Principal Sum Amount or [\$5,000] if a Covered Loss:

1. occurs while **you** are in the act of conducting business for or on any premises of the policyholder; and
2. is inflicted by persons other than fellow employees or members of **your** family or household; and
3. is the direct result of any of the following:
 - a. actual or attempted robbery or holdup;
 - b. actual or attempted kidnapping; or
 - c. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

“Fellow Employee” means a person employed by the same Employer or by an Employer that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined felonious assault was committed.

“Members of **your** family ” means **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner][**domestic partner**], **children**, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

“Members of your household” means a person who maintains residence at the same address as **you**.]

[Home Alteration and Vehicle Modification Benefit

If a Covered Loss occurs, except for loss of life, and it requires a home or vehicle to be modified, **we** will pay an additional benefit equal to the lesser of 10% of Your [or **your Dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or \$10,000, if all of the following

[Voluntary Accidental Death & Dismemberment]

conditions are met:

1. Prior to the date of the Covered Loss, **you** [or **your covered dependent**] did not require the use of any adaptive devices or adaptation of residence and/or vehicle; and
2. As a direct result of such Covered Loss, **you** [or **your covered dependent**] now require such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. **You** [or **your covered dependent**] require home alteration or vehicle modification within one year of the date of the Covered Loss.

[This provision is not applicable to **your covered dependents.**]]

[Public Transportation Benefit

An additional benefit will be paid, equal to the lesser of **your** [or **your dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or the Table of Losses, if **you** [or **your covered dependent**] loss is sustained while **you** [or **your covered dependent**] were a passenger in a common carrier that is licensed to transport people.

For the purposes of this benefit, the term "common carrier" means airplanes, ships, trains, subways, buses, taxis or trolleys.

[This provision is not applicable to **your covered dependents.**]]

Repatriation Benefit

If an accidental death benefit is payable for loss of **your** [or **your covered dependent's**] life and death occurs at least [100] miles away from **your** [or **your covered dependent's**] permanent place of residence, a maximum benefit not to exceed [\$2,000] or the actual expense incurred, will be paid for customary and reasonable expenses for preparation and transportation of **your** [or **your covered dependent's**] body to the place of burial or cremation.

[This provision is not applicable to **your covered dependents.**]

Seat Belt Benefit

If **you** [or **your covered dependent**] die as the result of an automobile accident which occurs while **you** [or **your covered dependent**] are driving or riding in an automobile, **we** will pay an additional benefit equal to the lesser of [10%] of Your [or **your dependent**] Voluntary Accidental Death and Dismemberment Principal Sum Amount or [\$10,000], if all of the following conditions are satisfied:

1. the seat belt was in actual use and was properly fastened at the time of the accident; and
2. **you** [or **your covered dependent**] were driving or riding in an automobile driven by a licensed driver who was neither intoxicated nor under the influence of drugs at the time of the accident. Intoxication and being under the influence of drugs shall be determined as defined by the law of the jurisdiction in which the accident occurred; and
3. the seat belt is certified in the official report of the accident, or by the investigating officer. A copy of the report must be submitted with the claim.

"Automobile" means a validly registered four-wheel passenger car, station

[Voluntary Accidental Death & Dismemberment]

wagon, jeep, pick-up truck or van-type vehicle. Legal State inspection is also required, if applicable.

"Seat belt" means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. "Seat belt" will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. "Seat belt" does not mean a shoulder restraint alone.

[This provision is not applicable to **your covered dependents**.]

Exclusions

A loss that is directly or indirectly a result of one or more of the following is not a Covered Loss even though it was caused by an accidental bodily **injury**:

1. bodily or mental infirmity or disease of any kind, or an infection (unless due to an accidental cut or wound); or
2. medical or surgical **treatment**, except where it is both: (a) **treatment** of an **injury** that meets the tests of a Covered Loss; and (b) **treatment** performed within 90 days after the **injury**; or
3. **your** [or **your covered dependent's**] participation in a war or an act of war, declared or undeclared; or
4. **your** [or **your covered dependent's**] service in the armed forces of any country or international authority for a period longer than 15 days; or
5. **your** [or **your covered dependent's**] unlawful participation in a riot, rebellion, or insurrection; or
6. **your** [or **your covered dependent's**] attempting to commit, or committing, an assault or felony; or
7. an intentionally self-inflicted **injury** or **illness** while sane or insane; or
8. suicide or attempted suicide whether sane or insane; or
9. riding in or descending from any kind of aircraft:
 - a. as a passenger on an aircraft operated by or for the armed forces; or
 - b. as a pilot or crewmember. (A crew member is anyone who has duties at any time on the flight, involving either the flight or the aircraft); or
 - c. as a participant in aviation training (student or instructor); or
 - d. as a participant in a sporting event or hobby; or]
10. **your** [or **your covered dependent's**] intoxication, as defined under the laws of the jurisdiction in which **your** [or **your covered dependent's**] Covered Loss occurred, except in the case of a narcotic that was administered or consumed on the advice of a **physician**]; or [
11. the voluntary taking of any kind of gas, except during the course of employment; the voluntary taking of any poison except in the case of accidental food poisoning]; or [
12. participating in any hazardous activity such as: Scuba Diving, Bungee Jumping, Skydiving, Hang Gliding, Ballooning, Drag Racing, Competitive Racing, Aerial Hunting, Aerial Skiing, and Parachuting]; or [

Voluntary Life Insurance

[Voluntary Accidental Death & Dismemberment]

13. work or service in a country that is included or has been included in the past six months on the International Travel Warning list that is issued by the U.S. Department of State (www.travel.state.gov.)
-

Notice

Written notice of claim should be given to **us** as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date of loss or as soon as reasonably possible.

Forms

When **we** receive notice of the claim, **we** will provide a claim form for filing a proof of loss. The form will be supplied to the claimant within 15 days of the day **we** receive notice of the claim.

If **we** do not provide a claim form within this 15-day period, the claimant may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character and extent of the loss.

Proof of Loss

Proof of loss must be sent to **us** within 90 days after the date of loss. A certified copy of a death certificate or other information **we** request must be given to **us** as proof of death.

We will not decline or reduce a claim if:

1. it is not reasonably possible to give proof within that time; and
2. the proof is submitted within one year from the date of loss or as soon as reasonably possible.

All proofs of loss must be satisfactory to **us**.

Time of Claim Payment

When **we** receive and approve the proof of loss, **we** will pay any benefits **we** owe under the **policy**.

Payment of Claims

A claim for loss of **your** life will be paid according to the Beneficiary provision. Claim payments for all other benefits are payable to **you**.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **we** receive written proof of loss; or
2. after 3 years from the time the claimant was required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** or the claimant if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** or the claimant does not agree with the reasons given, **you** or the claimant may request a reconsideration of that claim.

To do so, **you** or the claimant should write to **us** within [60 days] after **you** or the claimant receives the notice of denial. **You** or the claimant should say why **you** or the claimant believe the claim denial was not proper including any appropriate data, questions or comments. Unless **we** request additional material, **you** or the claimant will be advised of **our** decision within [60 days] after **we** receive the letter for you or the claimant.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** or **your beneficiary** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

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 Filing Company: Security Life Insurance Company of America State Tracking Number: 48317
 Company Tracking Number:
 TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: Premier Choice - Life
 Project Name/Number: Life Certificates/

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments:</p> <p>AR Certificate of Compliance - Life.pdf</p> <p>AR Certificate of Readability - Life.pdf</p> <p>AR Consumer Notice.pdf</p>		
<p>Satisfied - Item: Application</p> <p>Comments:</p> <p>approved 3/9/11 - SLIA-127053875</p> <p>Attachment:</p> <p>ERAPP.2010.pdf</p>		
<p>Satisfied - Item: Statement of Variability</p> <p>Comments:</p> <p>Attachment:</p> <p>Life SOV Final.pdf</p>		

Arkansas Certificate of Compliance

I hereby certify that Security Life Insurance Company of America will adhere to and comply with the following:

1. Pursuant to Rule and Regulation 49, the Life and Health Guaranty Notice will accompany every policy issued in the State of Arkansas; and
2. This submission meets the provisions of Rule and Regulation 19, as well as all applicable requirements of the Department; and
3. Pursuant to ACA 23-79-138 and Bulletin 11-88, the Arkansas Consumer Information Notice will accompany every policy issued in the State of Arkansas.



Bryan Anderson, Executive VP - Operations

March 22, 2011
Date

Arkansas Certificate of Readability

I hereby certify, that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
GP2010LBP-AR	51.0
GP2010LBP-R	51.3
GP2010VLBP-AR	53.4



Bryan Anderson, Executive VP - Operations

March 22, 2011

Date

ARKANSAS CONSUMER INFORMATION NOTICE

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

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494 or (501) 371-2640

PLEASE PRINT CLEARLY

General Information		
Employer's Full Legal Name (exactly as it will appear in the Contract): _____		
Coverages Requested (complete and attach an addendum for each coverage selected): <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Business is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
State of Incorporation: _____		
Tax ID Number:	Years in Business:	
Nature of Business:	SIC Code:	
For groups with 2 to 9 eligible employees: Is this a home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No	For groups with 2 to 9 eligible employees: Are 90% or more of the employees <input type="checkbox"/> Yes <input type="checkbox"/> No in the same family?	
Complete Street Address: Street _____ City _____ State _____ Zip _____ County _____		
Complete Mailing Address (if different): Street _____ City _____ State _____ Zip _____ County _____		
Contact Person:	Title:	
Email:	Telephone Number:	Fax Number:
Who should receive the initial Certificates and Administration Materials? <input type="checkbox"/> Employer— <i>Email required:</i> _____ <input type="checkbox"/> Producing Agent		
Type of Bill Requested: <input type="checkbox"/> List Bill <input type="checkbox"/> Self-Administered (Not available to groups <100 lives or groups applying for Dental or Vision)		
Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly (Not available for Dental or Vision)		
Easy-Pay Method (electronic transfer of premium): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, then Form# [EZPAY2008] must be completed.		

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: No Yes; if Yes, complete the following:

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 benefit, if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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 act, which is a crime.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

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.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with the 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF 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.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND 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.

Declarations**APPLICANT'S DECLARATION**

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

Signature of Officer or Owner

Print Name of Officer or Owner

Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

Signature of Agent

Print Name of Agent

Date

Address:

Telephone #:

License #:

Email:

HOME OFFICE USE:

Statement of Variability

Policy form number – GP2010LSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder
1	Coverage Effective Date	Original effective date of group contract
1	Plan Effective Date	Effective date of current group coverage
1	Open Enrollment Period	Provision will be either not included or included with date range.
1	Work Hours Required for Eligibility	Hours variable will range from [10-40] hours
1	Waiting Period	First Day variable will range from [0-365] or will be listed by month and range from [0-24]. Second Day variable will range from [0-365] or will be listed by month and range from [0-24]. Variable statements will be included if selected by policyholder.
1	Your Premium Contribution	Variable statement [not] will be included if the insured is not required to contribute towards coverage. Variable dependent statement will be included if there is dependent coverage. Variable supplemental statement will be included if there is supplemental coverage.
1	Base Life Insurance Amount	VARIABLE – life insurance dollar amount [\$1,000 - \$500,000] VARIABLE – multiplier [.5 – 5.0] VARIABLE – [next higher] or [[next lower] or [nearest] VARIABLE – dollar amount [\$500] or [\$1,000] VARIABLE – dollar amount [\$500 - \$50,000] VARIABLE – dollar amount [\$500 - \$50,000] VARIABLE – maximum dollar amount [\$15,000 - \$1,500,000] VARIABLE – minimum dollar amount [\$1,000 - \$75,000] Reduction Schedule VARIABLE - Statements / phrases / words will be in or out VARIABLE – age ranges {60-90} VARIABLE – percentage of scheduled benefit ranges {0-99} VARIABLE – dollar amount {\$1,000 - \$50,000} VARIABLE – minimum dollar amount {\$500-\$10,000}
2	Base Accidental Death and Dismemberment Principal Sum Amount	Provision will be included if selected by policyholder VARIABLE – life insurance dollar amount [\$1,000 - \$500,000] VARIABLE – multiplier [.5 – 5.0] VARIABLE – [next higher] or [[next lower] or [nearest] VARIABLE – dollar amount [\$500] or [\$1,000] VARIABLE – dollar amount [\$500 - \$50,000] VARIABLE – dollar amount [\$500 - \$50,000] VARIABLE – maximum dollar amount [\$15,000 - \$1,500,000] VARIABLE – minimum dollar amount [\$1,000 - \$75,000] Reduction Schedule VARIABLE - Statements / phrases / words will be in or out

		<p>VARIABLE – age ranges [60-90] VARIABLE – percentage of scheduled benefit ranges [0-99] VARIABLE – dollar amount [\$1,000 - \$50,000] VARIABLE – minimum dollar amount [\$500-\$10,000]</p>
2	Base Accidental Death and Dismemberment Additional Benefits	<p>Provision will be included if selected by policyholder. Benefits will be either included or not included</p>
2	Base Guarantee Issue Amount	<p>Provision will be included based upon coverage selected by policyholder. First Dollar amount variable [0-\$500,000] Second Dollar amount variable [\$0-\$1,500,000].</p>
2	Dependent Coverage	<p>Not included or included if dependent coverage is selected by policyholder.</p>
2	Dependent Life Insurance Amounts Available	<p>Provision will be included if dependent coverage is selected by policyholder. Spouse variables and Child variables will be included based on the type of dependent coverage selected.</p> <p>Spouse: dollar amount [\$1,000 – 50,000] percentage [10% – 75%] Child: Age Variable: [0-12] months to [0-30] years dollar amount [\$500 – \$25,000] percentage [10 – 50%] Infant: Age Variable: [0-365] days to [0-12] months dollar amount [\$100 - \$1000] percentage [10% – 75%]</p>
2	Dependent Student Age Limit	<p>Provision will be included if dependent coverage is selected. Age range [22-30]</p>
3	Supplemental Life Insurance Amounts	<p>Provision will be included if selected by policyholder.</p> <p>Employee: <i>VARIABLE – life insurance dollar amount [\$5,000 - \$500,000]</i> <i>VARIABLE – incremental dollar amount [\$1,000 - \$50,000]</i> <i>VARIABLE – multiplier [1 - 6]</i></p> <p><i>VARIABLE – multiplier [1.0 – 5.0]</i> <i>VARIABLE – incremental dollar amount [\$5,000 - \$500,000]</i> <i>VARIABLE – multiplier [1 - 6]</i></p> <p>Spouse: <i>VARIABLE – incremental dollar amount [\$1,000 - \$25,000]</i> <i>VARIABLE – life insurance dollar amount [\$5,000 - \$250,000]</i> <i>VARIABLE – percentage [5% – 100%]</i></p> <p>Child: Age Variable – [0-12] months to [0-30] years <i>VARIABLE – incremental dollar amount [\$1,000 - \$10,000]</i> <i>VARIABLE – life insurance dollar amount [\$5,000 - \$50,000]</i> <i>VARIABLE – percentage [5% – 50%]</i></p> <p>Infant Child: Age Variable – [0-365] days to [0-12] months <i>VARIABLE – dollar amount [\$100 - \$1,000]</i> <i>VARIABLE – percentage [10% - 75%]</i></p>

		<p>Reduction Schedule <i>VARIABLE - Statements / phrases / words will be in or out</i> <i>VARIABLE – age ranges {60-80}</i> <i>VARIABLE – percentage of scheduled benefit ranges {0-99}</i> <i>VARIABLE – dollar amount {\$1,000 - \$50,000}</i> <i>VARIABLE – minimum dollar amount {\$500-\$10,000}</i></p>
3 – 4	Supplemental Accidental Death and Dismemberment Amounts	<p>Provision will be included if selected by policyholder.</p> <p>Employee: <i>VARIABLE – life insurance dollar amount [\$5,000 - \$500,000]</i> <i>VARIABLE – incremental dollar amount [\$1,000 - \$50,000]</i> <i>VARIABLE – multiplier [1 - 6]</i></p> <p><i>VARIABLE – multiplier [1.0 – 5.0]</i> <i>VARIABLE – incremental dollar amount [\$5,000 - \$500,000]</i> <i>VARIABLE – multiplier [1 - 6]</i></p> <p>Spouse: <i>VARIABLE – incremental dollar amount [\$1,000 - \$25,000]</i> <i>VARIABLE – life insurance dollar amount [\$5,000 - \$250,000]</i> <i>VARIABLE – percentage [5% – 100%]</i></p> <p>Child: Age Variable – [0-12] months to [0-30] years <i>VARIABLE – incremental dollar amount [\$1,000 - \$10,000]</i> <i>VARIABLE – life insurance dollar amount [\$5,000 - \$50,000]</i> <i>VARIABLE – percentage [5% – 50%]</i></p> <p>Infant Child: Age Variable – [0-365] days to [0-12] months <i>VARIABLE – dollar amount [\$100 - \$1,000]</i> <i>VARIABLE – percentage [10% - 75%]</i></p> <p>Reduction Schedule <i>VARIABLE - Statements / phrases / words will be in or out</i> <i>VARIABLE – age ranges {60-80}</i> <i>VARIABLE – percentage of scheduled benefit ranges {0-99}</i> <i>VARIABLE – dollar amount {\$1,000 - \$50,000}</i> <i>VARIABLE – minimum dollar amount {\$500-\$10,000}</i></p>
4	Supplemental Accidental Death and Dismemberment Additional Benefits	<p>Provision will be included if selected by policyholder. Benefits will be either included or not included</p>
4	Supplemental Guarantee Issue Amount	<p>Employee variable [0-\$500,000] Spouse variable [0-\$250,000]</p>
4	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	<p>Temporary Layoff and applicable statement will be included if selected by policyholder. Injury or Illness variable based on policyholder selection. Months variable will range from [0-12]</p>

Policy form number – GP2010LBP

Defined Terms

Page #	Provision	Variables
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1	Annual Earnings	Statements will be included or not included based upon policyholder's selection. Month variables will range from [12-36]
2	Covered Dependent	Provision will be included if depended coverage is included.
2	Dependent	Section will be included if dependent coverage is selected by policyholder. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
3	Domestic Partner	Statement will be included or not included based on policyholder selection.
4	Evidence of Insurability	Variable statement will be included if dependent coverage is selected by policyholder.
4	Illness	Statement removable based on policyholder selection regarding waiver of premium.
4	Injury	Statement removable based on policyholder selection regarding waiver of premium.
4	Physician	Variable statement based on policyholder selection

Life Coverage – for you

7	Enrollment Requirement	The first variable statement will be included if there is no open enrollment period. The second variable statement will be included if there is an open enrollment period.
7	Termination of your Life Coverage	Variable statements will be included or not included if the policyholder selects [temporary layoff] and/or the portability provision.
8	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Variable statement [temporary layoff] will be included if selected by the policyholder.
8	Reinstatement	Variable statement concerning Portability will be included if the policyholder selects the portability provision
8-9	Continuation of Coverage During Total Disability	Provision variable for removal based on policyholder selection regarding waiver of premium Age variables will range from [60-90] Month variables will range from [3-12] Variable statement will be included if dependent coverage is selected by policyholder.
10	Continuity of Coverage	Provision variable for removal based on policyholder selection. Variable section will be included if selected by the policyholder.

Life Coverage – for your Dependents

11-12	Life Coverage – for your Dependents	Section will be included if dependent coverage is selected by policyholder.
11	Enrollment Requirement for your Dependent Life Coverage	The first variable statement will be included if there is no open enrollment period. The second variable statement will

		be included if there is an open enrollment period.
12	Evidence of Insurability Requirement for your Dependent Life Coverage	Variable statement included based on policyholder selection.

Life Benefit

13	Death Benefit	Variable statement will be included if dependent coverage is selected by policyholder.
13	Beneficiary	Assignment variable based on whether the Assignment provision has been included. Variable statement will be included if dependent coverage is selected by policyholder.
13	Assignment	Provision variable based on policyholder selection. Variable statement will be included if dependent coverage is selected by policyholder.
13	Exclusion	Provision included or not included based on policyholder selection. Variable statements will be included if dependent coverage is selected by policyholder.

Portability Benefit

14-15	Portability Benefit	Section and statements will be included if selected by policyholder. Base life and Supplemental life variables based on coverages included. Variable statements referencing dependents will be included if dependent coverage is selected by policyholder. Age variables will range from [60-90]. Month variable will range from [6-24] months. Variable statement [and pay required premium] will be either included or not included.
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Conversion Privilege

16-17	Conversion Privilege	Variable statements referencing dependents will be included if dependent coverage is selected by policyholder. Year variable will range from [1-7] years. Amount variable will range from [\$1,000-\$25,000].
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Accelerated Benefit – for Limited Life Expectancy

18	Administrative Charge	Amount variable will range from [\$100-\$500].
18	Amount payable	Percentage variables will range from [10%-75%]. Amount variable will range from [\$10,000-\$375,000]

Accidental Death & Dismemberment

20-27	Accidental Death & Dismemberment	Section will be included if AD&D coverage is selected by policyholder.
20	Effective Date of your [and your Dependents] Accidental Death and Dismemberment Coverage	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
20	Termination of your [and your Dependents] Accidental Death and	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.

	Dismemberment Coverage	
20	Benefit Payable	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
20	Covered Loss	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
21	Air Bag Benefit	Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Percentage variable will range from [5%-25%]. Amount variable will range from [\$5,000- \$50,000].
22	Brain Damage Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected. Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000]
22-23	Coma Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected. Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000]
23	Common Accident Benefit	Provision included or not included based on policyholder selection. Time variable [2 months – 1 year], 3 month standard
23	Education Benefit	Provision will be included if AD&D coverage and this benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Benefit payable variable will range from [\$1,000-\$10,000].
24	Exposure and Disappearance Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected.
24	Felonious Assault Benefit	Provision included or not included based on selection Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000] [domestic partner] variable based on policyholder selection
24-25	Home Alteration and Vehicle Modification Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected.
25	Public Transportation Benefit	Provision will be included if AD&D coverage and this benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage.
25	Repatriation Benefit	Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Amount variable will range from [\$1000-\$25,000].
25-26	Seat Belt Benefit	Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage.

		Percentage variable will range from [5%-25%]. Amount variable will range from [\$5,000-\$50,000].
26-27	Exclusions	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder. Variable statements will be included or not included based on policyholder selection.

Claim Provisions

29	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
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Policy form number – GP2010LSB-R

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder
1	Coverage Life Effective Date	Effective date of group contract
1	Plan Date	Effective date of the insured's life coverage
1	Your Premium Contribution	Word variable [Not] will be in or out based on policyholder selection.
1	Your Life Insurance Amount	VARIABLE – life insurance dollar amount [\$500 - \$100,000] VARIABLE – percentage [5% -100%] VARIABLE – dollar amount [\$5,000 - \$100,000] VARIABLE – percentage [5% -25%] VARIABLE – dollar amount [\$500 - \$50,000] Reduction Schedule VARIABLE - Statements / phrases / words will be in or out VARIABLE – age ranges {60-80} VARIABLE – percentage of scheduled benefit ranges {0-99} VARIABLE – dollar amount {\$1,000 - \$50,000} VARIABLE – minimum dollar amount {\$500-\$10,000}

Policy form number – GP2010LBP-R

Life Benefit

3	Beneficiary	Variable included if Assignment provision included.
3	Assignment	Provision will be included or not included based on policyholder selection.
3	Exclusion	Provision will be included or not included based on policyholder selection.

Conversion Privilege

4	Conversion Privilege	Year variable will range from [1-7] years. Amount variable will range from [\$1,000-\$25,000].
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Claim Provisions

7	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
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Policy form number – GP2010VLSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder
1	Coverage Effective Date	Original effective date of group contract
1	Plan Effective Date	Effective date of current group coverage
1	Open Enrollment Period	Provision will be either not included or included with date range and guarantee issue language. Age variable will range from [50-65]. Amount will range from [\$1,000-\$50,000].
1	Work Hours Required for Eligibility	Hours variable will range from [10-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0-24]. Variable statements will be included if selected by policyholder.
1-2	Voluntary Life Insurance Amount	<p>Employee: Amounts variable will range from [\$5,000-\$750,000]. Increments variable will range from [\$500-\$50,000]. Maximum benefits variable will range from [\$5,000-\$1,000,000]. Multiples of annual earnings variable will range from [1-8] times. Rounding variable will range from [\$500-\$10,000] to either the next higher or next lower or nearest.</p> <p>Spouse: Variable based on dependent coverage selected Amount variable will range from [\$5,000-\$500,000]. Increments variable will range from [\$500-\$25,000]. Maximum benefits variable will range from [\$5,000-\$500,000]. Rounding variable will range from [\$500-\$5,000] to either the next higher or next lower or nearest. Percentage variables will range from [10-75%]</p> <p>Child: Variable based on dependent coverage selected Age variable will range from [0-12] months to [0-30] years Amount variable will range from [\$100 - \$50,000]. Increments variable will range from [\$100-\$2,000]. Maximum benefit variable will range from [\$1,000-\$50,000].</p> <p>Infant Child: Age variable will range from [0 – 365] days to [0 –12] months.</p> <p>Amount variable will range from [\$100-\$25,000]. Percentage variable will range from [10% - 75%]</p> <p>Age reduction schedule may not be included based upon</p>

		<p>policyholder selection. If an age reduction schedule is included, age variables will range from [60-90]. Percentage variables will range from [0-99%]. Dollar amount variables will range from [\$0-\$250,000]</p>
2-3	<p>Voluntary Accidental Death and Dismemberment Principal Sum Amount</p>	<p>Employee: Provision will be included if selected by policyholder. Amounts variable will range from [\$5,000-\$750,000]. Increments variable will range from [\$500-\$50,000]. Maximum benefits variable will range from [\$5,000-\$1,000,000]. Multiples of annual earnings variable will range from [1-8] times. Rounding variable will range from [\$500-\$10,000] to either the next higher or next lower or nearest.</p> <p>Spouse: Variable based on dependent coverage selected Amount variable will range from [\$5,000-\$500,000]. Increments variable will range from [\$500-\$10,000]. Maximum benefits variable will range from [\$5,000-\$500,000]. Rounding variable will range from [\$500-\$5,000] to either the next higher or next lower or nearest. Percentage variables will range from [10-75%]</p> <p>Child: Variable based on dependent coverage selected Age variable will range from [0-12] months to [0-30] years Amount variable will range from [\$100 - \$50,000]. Increments variable will range from [\$100 - \$2,000]. Maximum benefit variable will range from [\$1,000-\$50,000]</p> <p>Infant Child Age variable will range from [0 – 365] days to [0 –12] months. Amount variable will range from [\$100 - \$25,000]. Percentage variable will range from [10% - 75%]</p> <p>Age reduction schedule may not be included based upon policyholder selection. If an age reduction schedule is included, age variables will range from [60-90]. Percentage variables will range from [0-99%]. Dollar amount variables will range from [\$0-\$250,000]</p>
3-4	<p>Voluntary Accidental Death and Dismemberment Additional Benefits</p>	<p>Provision will be included if selected by policyholder. Benefits will be either included or not included</p>
4	<p>Guarantee Issue Amount</p>	<p>Provision will be included based upon coverage selected by policyholder. Employee benefit variable will range from [\$0-\$500,000]. Age variable will range from [60-75]. Percentage variable will range from [0-75%]. Spouse benefit variable will range from [\$0-\$250,000]. Age variable will range from [60-75]. Percentage variable will range from [0-75%].</p>
4	<p>Dependent Coverage</p>	<p>Provision will be included if dependent coverage is selected</p>

		by policyholder.
4	Dependent Student Age Limit	Provision will be included if dependent coverage is selected by policyholder. Age will range from [22-30]
4	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Temporary Layoff and applicable statement will be included if selected by policyholder. Injury or Illness variable based on policyholder selection. Months variable will range from [0-12].

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Defined Terms

Page #	Provision	Variables
1	Annual Earnings	Statements will be included or not included based upon policyholder's selection. Month variables will range from [12-36]
2	Covered Dependent	Provision will be included if depended coverage is included.
2-3	Dependent	Section will be included if dependent coverage is selected by policyholder. #3 – variable for removal if there is no dependent student criteria #4 – standard variable is [attaining the Dependent Student Age Limit, [age [19]] to be used if there is no dependent student criteria Age limit – Standard age limit is 19, age variable to increase based on state requirement or to match existing coverage.
3	Domestic Partner	Statement will be included or not included based on policyholder selection.
3	Evidence of Insurability	Variable statement will be included if dependent coverage is selected by policyholder.
4	Illness	Statement removable based on policyholder selection regarding waiver of premium.
4	Injury	Statement removable based on policyholder selection regarding waiver of premium.
4	Physician	Variable statement based on policyholder selection

Voluntary Life Coverage – for you

6	Effective Date of your Voluntary Life Coverage	Variable statement based on policyholder selection.
6-7	Enrollment Requirement	The first variable statement will be included if there is no open enrollment period. The second variable statement will be included if there is an open enrollment period. The third variable statement will be included if dependent coverage is selected by policyholder.
7	Evidence of Insurability Requirement	Variable statement will be included if there is an open enrollment period. Age will range from [50-65]. Amount will range from [\$1,000-\$50,000]
7-8	Termination of your Voluntary Life Coverage	Variable statements will be included or not included if the policyholder selects the continuation provision and/or portability provision.
8	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or	Variable statement [temporary layoff] will be included if selected by the policyholder.

	other Leave of Absence	
8	Reinstatement	Month variable will range from [3-24]. Variable statement concerning Portability will be included if the policyholder selects the portability provision
8-9	Continuation of Coverage During Total Disability	Provision variable for removal based on policyholder selection regarding waiver of premium Age variables will range from [60-90]. Month variables will range from [3-12]. Variable statement will be included if dependent coverage is selected by policyholder.
10	Continuity of Coverage	Provision variable for removal based on policyholder selection. Variable statement will be included if selected by the policyholder.

Voluntary Life Coverage – for your Dependents

11-13	Voluntary Life Coverage – for your Dependents	Section will be included if dependent coverage is selected by policyholder.
11	Eligibility Requirements for your Dependent Voluntary Life Insurance	The first variable statement will be included if there is an open enrollment period. The second variable statement will be included if there is no open enrollment period.
11-12	Enrollment Requirement for your Dependent Voluntary Life Coverage	The first variable statement will be included if there is no open enrollment period. The second variable statement will be included if there is an open enrollment period.
12	Evidence of Insurability Requirement for your Dependent Voluntary Life Coverage	Variable statement included based on policyholder selection.
12	Effective Date of Changes in your Dependent Voluntary Life Coverage Amount	Day variable will range from [7-14] days

Voluntary Life Benefit

14	Death Benefit	Variable statements will be included if dependent coverage is selected by policyholder.
14	Beneficiary	Assignment variable based on whether the Assignment provision has been included. Variable statement will be included if dependent coverage is selected by policyholder.
14	Assignment	Provision variable based on policyholder selection. Variable statement will be included if dependent coverage is selected by policyholder.
14	Exclusion	Provision included or not included based on policyholder selection. Variable statements will be included if dependent coverage is selected by policyholder.

Portability Benefit

15-16	Portability Benefit	Section will be included if selected by policyholder. Variable statements referencing dependents will be included if dependent coverage is selected by policyholder. Age variables will range from [60-90]. Month variable will
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		range from [6-24] months. Variable statement [and pay required premium] will be either included or not included.
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Conversion Privilege

17-18	Conversion Privilege	Variable statements referencing dependents will be included if dependent coverage is selected by policyholder. Year variable will range from [1-7] years. Amount variable will range from [\$1,000-\$25,000].
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Accelerated Benefit – for Limited Life Expectancy

19	Requirements	Month variable will range from [6-18] months
19	Administrative Charge	Amount variable will range from [\$100-\$500].
19	Amount payable	Percentage variables will range from [10%-75%]. Amount variable will range from [\$50,000-\$375,000]

Voluntary Accidental Death & Dismemberment

21-27	Voluntary Accidental Death & Dismemberment	Section will be included if AD&D coverage is selected by policyholder.
21	Effective Date of your [and your Dependents] Voluntary Accidental Death and Dismemberment Coverage	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
21	Termination of your [and your Dependents] Voluntary Accidental Death and Dismemberment Coverage	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
21	Benefit Payable	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
21	Covered Loss	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder.
22	Air Bag Benefit	Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Percentage variable will range from [5%-25%]. Amount variable will range from [\$5,000- \$50,000].
23	Brain Damage Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected. Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000]
23-24	Coma Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected. Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000]
24	Common Accident Benefit	Provision included or not included based on policyholder selection. Time variable [2 months – 1 year]
24	Education Benefit	Provision will be included if AD&D coverage and this

		benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Benefit payable variable will range from [\$1,000-\$10,000].
25	Exposure and Disappearance Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected.
25	Felonious Assault Benefit	Provision included or not included based on selection Percentage variable will range from [5%-10%] Dollar amount variable will range from [\$5,000 - \$10,000] [domestic partner] variable based on policyholder selection
25-26	Home Alteration and Vehicle Modification Benefit	Provision included or not included based on selection Variable statements referencing dependents will be included or not included based on dependent coverage selected.
26	Public Transportation Benefit	Provision will be included if AD&D coverage and this benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage.
26	Repatriation Benefit	Provision will be included if AD&D coverage and this benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Miles variable will range from [75-250] miles. Amount variable will range from [\$1,000-\$25,000].
26-27	Seat Belt Benefit	Provision will be included if AD&D coverage and this benefit option are selected by policyholder. Variable statements referencing dependents will be included or not included if policyholder selects dependent coverage. Percentage variable will range from [5%-25%]. Amount variable will range from [\$5,000-\$50,000].
27	Exclusions	Variable statements referencing dependents will be included if dependent AD&D coverage is selected by policyholder. Variable statements will be included or not included based on policyholder selection.

Claim Provisions

29	Reconsideration of a Denied Claim	First day variable will range from [60-365] days. Second day variable will range from [30-180] days.
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