

SERFF Tracking Number: SLIA-127087004 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48339
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: Premier Choice - LTD
Project Name/Number: /

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Premier Choice - LTD SERFF Tr Num: SLIA-127087004 State: Arkansas
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 48339
Closed

Sub-TOI: H11G.003 Long Term Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Stacy Patacsil Disposition Date: 03/30/2011
Date Submitted: 03/25/2011 Disposition Status: Approved-
Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: 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: 03/30/2011
State Status Changed: 03/30/2011 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.

ERAPPLTD2-9.2010 – Long Term Disability Insurance 2 to 9 Product Addendum
ERAPPLTD.2010 – Long Term Disability Insurance 10+ Product Addendum
ERAPPVOLLTD.2010 – Voluntary Long Term Disability Insurance Product Addendum
ERAPPLTDCORE/BUYUP.2010 – Long Term Disability Insurance Core/Buy-Up Product Addendum

GP2010TSB - LTD Schedule of Benefits
GP2010TBP - LTD Benefit Provisions

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GP2010VTSB - Voluntary LTD Schedule of Benefits

GP2010VTBP - Voluntary LTD 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 Long Term Disability 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.

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

SERFF Tracking Number: SLIA-127087004 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48339
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
 Product Name: Premier Choice - LTD
 Project Name/Number: /
 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: \$400.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$400.00	03/25/2011	45957667

SERFF Tracking Number: SLIA-127087004 State: Arkansas
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TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: Premier Choice - LTD
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/30/2011	03/30/2011

SERFF Tracking Number: SLIA-127087004 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48339
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
Product Name: Premier Choice - LTD
Project Name/Number: /

Disposition

Disposition Date: 03/30/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SLIA-127087004 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48339
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
 Product Name: Premier Choice - LTD
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	LTD Insurance 2 to 9 Product Addendum	Approved-Closed	Yes
Form	LTD Insurance 10+ Product Addendum	Approved-Closed	Yes
Form	Voluntary LTD Insurance Product Addendum	Approved-Closed	Yes
Form	LTD Insurance Core/BuyUp Product Addendum	Approved-Closed	Yes
Form	LTD Schedule of Benefits	Approved-Closed	Yes
Form	LTD Benefit Provisions	Approved-Closed	Yes
Form	Voluntary LTD Schedule of Benefits	Approved-Closed	Yes
Form	Voluntary LTD Benefit Provisions	Approved-Closed	Yes

SERFF Tracking Number: SLIA-127087004 State: Arkansas
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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ERAPPLTD2-9.2010	Application/Enrollment Form	LTD Insurance 2 to 9 Product Addendum	Initial		0.000	ERAPPLTD2-9.2010.pdf
Approved-Closed	ERAPPLTD.2010	Application/Enrollment Form	LTD Insurance 10+ Product Addendum	Initial		0.000	ERAPPLTD.2010.pdf
Approved-Closed	ERAPPVOLLTD.2010	Application/Enrollment Form	Voluntary LTD Insurance Product Addendum	Initial		0.000	ERAPPVOLLTD.2010.pdf
Approved-Closed	ERAPPLTD COREBUY UP.2010	Application/Enrollment Form	LTD Insurance Core/BuyUp Product Addendum	Initial		0.000	ERAPPLTD COREBUY UP.2010.pdf
Approved-Closed	GP2010TS B	Schedule Pages	LTD Schedule of Benefits	Initial		0.000	GP2010TSB.pdf
Approved-Closed	GP2010TB P	Certificate	LTD Benefit Provisions	Initial		0.000	GP2010TBP.pdf
Approved-Closed	GP2010VT SB	Schedule Pages	Voluntary LTD Schedule of Benefits	Initial		0.000	GP2010VTSB.pdf
Approved-Closed	GP2010VT BP	Certificate	Voluntary LTD Benefit Provisions	Initial		0.000	GP2010VTBP.pdf

**Security Life Insurance Company of America
Long Term Disability Insurance 2 to 9 Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Long Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," list current carrier and attach a copy of the certificate and the latest billing statement. Current Carrier:	
Will this coverage applied for replace the current coverage, if any? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," provide explanation:	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Tax ID # is required:	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility (min. 30 hours):
Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: _____% If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	
Eligibility Waiting Period (minimum 30 days): <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	

Plan Information
Benefit Amount * : 60% to a Maximum of \$ _____ per month *excludes commissions, bonuses, overtime and other extra compensation
Minimum Monthly Benefit Amount: Greater of \$100 or 10%
Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days
Maximum Benefit Duration: <input type="checkbox"/> SSNRA <input type="checkbox"/> RBD <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 2 Yrs <input type="checkbox"/> Other _____
Definition of Total Disability (own occ period): <input type="checkbox"/> 2 Yrs <input type="checkbox"/> 3 Yrs <input type="checkbox"/> 5 Yrs <input type="checkbox"/> Other _____
Social Security Integration: Primary/Family
Survivor Benefit: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Other _____
Pre-Existing Condition Limitation: Included
Limitations: 24 month maximum benefit period for Mental Illness; Alcohol and Drug; and other Special Conditions (self-reported symptom claims)
Residual Disability Benefit: Included

Long Term Disability 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 for at least 5 consecutive working days? Yes No

If Yes, give details below.

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 incurred medical expenses that exceeded \$10,000? Yes No

If Yes, give details below.

Name of Employee	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

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

Home Office Use:

**Security Life Insurance Company of America
Long Term Disability 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 Long Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If Yes, Tax ID # is required:</small>	

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: _____ % If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	If "Yes," Amount EMPLOYEE Contributes: _____ % If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis
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
Benefit Amount: _____ % to a Maximum of \$_____ per month	Benefit Amount: _____ % to a Maximum of \$_____ per month
Minimum Monthly Benefit Amount: <input type="checkbox"/> Greater of \$100 or 10% <input type="checkbox"/> \$100 <input type="checkbox"/> Greater of \$50 or 10% <input type="checkbox"/> \$50	Minimum Monthly Benefit Amount: <input type="checkbox"/> Greater of \$100 or 10% <input type="checkbox"/> \$100 <input type="checkbox"/> Greater of \$50 or 10% <input type="checkbox"/> \$50
Monthly Earnings Definition: <input type="checkbox"/> Base Monthly Earnings <input type="checkbox"/> Base Monthly Earnings plus averaged 24 mo. commissions <input type="checkbox"/> Other _____	Monthly Earnings Definition: <input type="checkbox"/> Base Monthly Earnings <input type="checkbox"/> Base Monthly Earnings plus averaged 24 mo. commissions <input type="checkbox"/> Other _____
Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other _____	Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other _____
Maximum Benefit Duration: <input type="checkbox"/> SSNRA <input type="checkbox"/> RBD <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 2 Yrs <input type="checkbox"/> Other _____	Maximum Benefit Duration: <input type="checkbox"/> SSNRA <input type="checkbox"/> RBD <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 2 Yrs <input type="checkbox"/> Other _____
Definition of Total Disability (own occ period): <input type="checkbox"/> 2 Yrs <input type="checkbox"/> 3 Yrs <input type="checkbox"/> 5 Yrs <input type="checkbox"/> To Age 65	Definition of Total Disability (own occ period): <input type="checkbox"/> 2 Yrs <input type="checkbox"/> 3 Yrs <input type="checkbox"/> 5 Yrs <input type="checkbox"/> To Age 65

Long Term Disability Insurance 10+ Product Addendum

Class A (cont.)	Class B (cont.)
<p>SS Integration: <input type="checkbox"/> Primary/Family <input type="checkbox"/> Primary only</p> <p>Survivor Benefit: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Other _____</p> <p>Pre-Existing Condition Limitation: Included</p> <p>Residual Disability Benefit: Included</p> <p>24 month Special Conditions Limitation: <input type="checkbox"/> Included <input type="checkbox"/> Not Included (If Not Included, Standard 24 month Mental Illness; and Alcohol and Drug Abuse Limitation Applies)</p>	<p>SS Integration: <input type="checkbox"/> Primary/Family <input type="checkbox"/> Primary only</p> <p>Survivor Benefit: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> Other _____</p> <p>Pre-Existing Condition Limitation: Included</p> <p>Residual Disability Benefit: Included</p> <p>24 month Special Conditions Limitation: <input type="checkbox"/> Included <input type="checkbox"/> Not Included (If Not Included, Standard 24 month Mental Illness; and Alcohol and Drug Abuse Limitation Applies)</p>
<p>Additional Benefit Options:</p> <p>Accidental Dismemberment and Loss of Sight Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p> <p>Child Care Expense Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p> <p>Progressive Income Benefit (based on Activities of Daily Living): <input type="checkbox"/> Yes, 10% <input type="checkbox"/> Yes, 20% <input type="checkbox"/> No</p> <p>Cost of Living Adjustment (COLA): <input type="checkbox"/> Included <input type="checkbox"/> Not Included If Included, _____%; Duration _____</p> <p>Pension Contribution Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>401(k) Contribution Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>COBRA Premium Disability Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>Spouse and Elder Care Expense Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>Advanced Survivor Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p>	<p>Additional Benefit Options:</p> <p>Accidental Dismemberment and Loss of Sight Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p> <p>Child Care Expense Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p> <p>Progressive Income Benefit (based on Activities of Daily Living): <input type="checkbox"/> Yes, 10% <input type="checkbox"/> Yes, 20% <input type="checkbox"/> No</p> <p>Cost of Living Adjustment (COLA): <input type="checkbox"/> Included <input type="checkbox"/> Not Included If Included, _____%; Duration _____</p> <p>Pension Contribution Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>401(k) Contribution Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>COBRA Premium Disability Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>Spouse and Elder Care Expense Benefit: <input type="checkbox"/> Included _____% <input type="checkbox"/> Not Included</p> <p>Advanced Survivor Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p>

Long Term Disability Insurance 10+ Product Addendum

Actively at Work — Employee Information

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

If Yes, give details below.

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 Company of America.

Home Office Use:

Security Life Insurance Company of America
Voluntary Long Term Disability 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 Voluntary Long Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If Yes, Tax ID # is required:</small>	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility:
Employee Premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	
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
Benefit Amount: _____ % to a Maximum of \$ _____ per month
Minimum Monthly Benefit Amount: <input type="checkbox"/> Greater of \$100 or 10% <input type="checkbox"/> \$100 <input type="checkbox"/> Greater of \$50 or 10% <input type="checkbox"/> \$50
Monthly Earnings Definition: <input type="checkbox"/> Base Monthly Earnings <input type="checkbox"/> Base Monthly Earnings plus averaged 24 month commissions <input type="checkbox"/> Other _____
Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other _____
Maximum Benefit Duration: <input type="checkbox"/> SSNRA <input type="checkbox"/> RBD <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 2 Yrs <input type="checkbox"/> Other _____
Definition of Total Disability (own occ period): 2 Yrs
SS Integration: Primary/Family
Survivor Benefit: <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____
Pre-Existing Condition Limitation: Included
Residual Disability Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included (Partial Only)
24 month Special Conditions Limitation: Included <small>(Includes 24 month Mental Illness; and Alcohol and Drug Abuse Limitation)</small>

Voluntary Long Term Disability Insurance 10+ Product Addendum

Actively at Work — Employee Information

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

If Yes, give details below.

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 Company of America.

Home Office Use:

**Security Life Insurance Company of America
Long Term Disability Insurance Core/Buy-up Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Long Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If Yes, Tax ID # is required:</small>	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility: _____
Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	
CORE Plan: EMPLOYER Contributes: 100%	
OPTIONAL (Buy-up) Plan: EMPLOYEE Contributes: 100% Premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	

Plan Information	
CORE Benefit Amount: <input type="checkbox"/> _____% to a maximum of \$_____ per month	
OPTIONAL (Buy-up) Benefit Amount: <input type="checkbox"/> _____% to a maximum of \$_____ per month, minus the core benefit amount	
Minimum Monthly Benefit Amount: <input type="checkbox"/> Greater of \$100 or 10% <input type="checkbox"/> \$100 <input type="checkbox"/> Greater of \$50 or 10% <input type="checkbox"/> \$50	
Monthly Earnings Definition: <input type="checkbox"/> Base Monthly Earnings <input type="checkbox"/> Base Monthly Earnings plus averaged 24 months commissions <input type="checkbox"/> Other _____	
Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other _____	
Maximum Benefit Duration: <input type="checkbox"/> SSNRA <input type="checkbox"/> RBD <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 2 Yrs	
Definition of Total Disability (own occ period): <input type="checkbox"/> 2 Yrs <input type="checkbox"/> 3 Yrs <input type="checkbox"/> 5 Yrs <input type="checkbox"/> To Age 65	

Long Term Disability Insurance Core/Buy-up Product Addendum

Plan Information (Continued)

SS Integration: Primary/Family Primary only

Survivor Benefit: 3 Months 6 Months Other _____

Pre-Existing Condition Limitation: Included

Residual Disability Benefit: Included

24 month Special Conditions Limitation: Included Not Included

(If Not Included, Standard 24 month Mental Illness; and Alcohol and Drug Abuse Limitation Applies)

Additional Benefit Options:

Accidental Dismemberment and Loss of Sight Benefit: Included Not Included

Child Care Expense Benefit: Included Not Included

Progressive Income Benefit (based on Activities of Daily Living): Yes, 10% Yes, 20% No

Cost of Living Adjustment (COLA): Included _____%; Duration _____ Not Included

Pension Contribution Benefit: Included _____% Not Included

401(k) Contribution Benefit: Included _____% Not Included

COBRA Premium Disability Benefit: Included _____% Not Included

Spouse and Elder Care Expense Benefit: Included _____% Not Included

Advanced Survivor Benefit: Included Not Included

Actively at Work — Employee Information

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

If Yes, give details below.

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.

Long Term Disability Insurance Core/Buy-up 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:

Long Term Disability Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[06/01/2010]
Plan Effective Date	[06/01/2010]
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	For your 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 [not] required to contribute towards the cost of your coverage . [You are required to contribute towards the cost of your Optional Monthly Benefit Amount.]
Your Monthly Benefit Amount	[Your [Core] Monthly Benefit Amount will be equal to the lesser of: <ol style="list-style-type: none">[60%] of your monthly earnings; or[\$3,000] maximum monthly benefit, minus any income listed in Benefit Reductions.] [Your [Core] Monthly Benefit Amount will be equal to [\$2,000] not to exceed [60%] of your monthly earnings minus any income listed in Benefit Reductions.] [Your optional Monthly Benefit Amount, if you enrolled, will be equal to the lesser of: <ol style="list-style-type: none">[80%] of your monthly earnings; or[\$5,000] maximum monthly benefit, minus your Core Monthly Benefit Amount and any income listed in Benefit Reductions.]

Long Term Disability Insurance

Schedule of Benefits

[Your optional Monthly Benefit Amount, if you enrolled, is [\$4,000] not to exceed [60%] of your monthly earnings, minus your Core Monthly Benefit Amount and any income listed in Benefit Reductions.]

[After applying the Benefit Reductions, the minimum monthly benefit will be [the greater of: (a) [10%] of your Monthly Benefit Amount; or (b)] [\$100].]

[Guarantee maximum benefit amount: [\$3,000]. [Monthly Benefit Amounts in excess of the guarantee maximum benefit amount will be subject to our approval of your evidence of insurability.]

Residual Disability Benefit

[Included. The Elimination Period can be satisfied with days of partial or total disability.] [Not Included.]

Elimination Period

[The later of] [90 days] [or the end of your accumulated sick leave with the covered employer.]

Regular Occupation Period

[[24 months] of benefit payments.] [Duration of the Maximum Benefit Period.]

Maximum Benefit Period

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 60

to your normal retirement age

age 60

to your normal retirement age, but not less than 60 months

age 61

to your normal retirement age, but not less than 48 months

age 62

to your normal retirement age, but not less than 42 months

age 63

to your normal retirement age, but not less than 36 months

age 64

to your normal retirement age, but not less than 30 months

age 65

24 months

age 66

21 months

age 67

18 months

age 68

15 months

age 69 or older

12 months

Your normal retirement age is your retirement age based on the 1983 amendment to the Social Security Act where retirement age depends on your year of birth, as follows:

Long Term Disability Insurance

Schedule of Benefits

YEAR OF BIRTH	SOCIAL SECURITY NORMAL RETIREMENT AGE:
1937 or before	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 & after	67 years]
[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 67	3 years
ages 67 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]
[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 68	2 years
ages 68 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]
[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 61	60 months
age 61	48 months
age 62	42 months
age 63	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]
[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 64	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months

Long Term Disability Insurance

Schedule of Benefits

age 69 or older 12 months]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 66	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 60	age 65
age 60	60 months
age 61	48 months
age 62	42 months
age 63	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 60	to age 65
ages 60 through 64	5 years
ages 65 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 70	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

MAXIMUM BENEFIT PERIOD:

under age 60	10 years
ages 60 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN

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DISABILITY BEGINS:

under age 65
ages 65 through 69
age 70 and older

MAXIMUM BENEFIT PERIOD:

5 years
to age 70 but not less than 1 year
1 year]

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.]

Injury or Illness – 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).

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).

Survivor Benefit

Included.

[Advanced Survivor Benefit

Included.]

[Child Care Expense Benefit

Included.]

[Cost of Living Adjustment Benefit

Included.]

[Medical or COBRA Premium Disability Benefit

Included.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

Included.]

[Pension Contribution Benefit

Included.]

[Progressive Income Benefit

Included.]

[Reasonable Accommodation Expense Benefit

Included.]

Long Term Disability Insurance

Schedule of Benefits

[Spouse and Elder Care Expense Benefit	Included.]
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[401(k) Contribution Benefit	Included.]
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[Alcohol and Drug Abuse Limitation	Included.]
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[Mental Illness Limitation	Included.]
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[Special Conditions Limitation	Included.]
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Long Term Disability Insurance

Defined Terms

[Activities of Daily Living (ADL)]

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).]

Appropriate Care

You:

1. regularly visit a **physician** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s); and
2. receive care or **treatment** appropriate for the disabling condition(s), conforming with standard medical practice, by a **physician** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize **your** disabling condition including corrective **treatment** or minor surgery.

[Cognitive Impairment]

A deterioration or loss in **your** intellectual capacity, resulting from **injury, illness, Alzheimer's disease** or similar forms of irreversible dementia that results in **your** needing another person's continuous active help or verbal guidance for **your** own protection or for the protection of others. Determination of the deterioration or loss will be based on clinical evidence and/or clinical tests, according to generally accepted medical standards, that reliably measure **your** impairment.

No benefits are provided for **cognitive impairments** that begin prior to the date **you** become a **covered person**.]

Disability, Disabled

Total Disability or **Partial Disability** and **Totally Disabled** or **Partially Disabled**.

Disability Earnings

The earnings which **you** receive while **you** are **disabled** and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

Eligible Survivor

Your spouse, if living; otherwise **your** children under age 25. Any payment

Long Term Disability Insurance

Defined Terms

due **your** children will be paid in equal shares. Payment may be made to a person named by **us** to receive the payment on **your** children's behalf. This payment will be valid against all claims by others representing or claiming to represent the children.

Elimination Period

The initial number of consecutive days of a **period of disability** for which no benefit is payable under the **policy**.

We will count only those days **you** are **totally disabled** to satisfy the **elimination period**. If a Residual Disability Benefit is included as shown in the Schedule of Benefits, **we** will also include those days that **you** are **partially disabled**. If **you** return to work full-time for no more than [14] calendar days during the **elimination period**, **we** will treat the **disability** as continuous. The Elimination Period is shown in the Schedule of Benefits.

Evidence of Insurability

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

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

Gainful Occupation

An occupation that is or can be expected to provide **you** with an income within 12 months of **your** return to work, that exceeds:

1. [80%] of **your indexed monthly earnings**, if **you** are working; or
2. [60%] of **your indexed monthly earnings**, if **you** are not working.

Gross Monthly Benefit

Your benefit before adjustments for Benefit Reductions and **disability earnings**.

Hospital, Health Facility or Institution

An accredited facility licensed to provide care for the condition causing **your disability**.

Hospital Confined

You are confined as an in-patient in a **hospital, health facility or institution**.

Illness

Your medically determinable sickness, disease or pregnancy.

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

Indexed Monthly Earnings

Your monthly earnings, as adjusted on the first anniversary of benefit payments and each anniversary thereafter. To adjust **your monthly earnings**, **we** will add the lesser of the following to **your monthly earnings**:

Long Term Disability Insurance

Defined Terms

1. 10% of **your monthly earnings**; or
2. the annual percentage increase in the U.S. Bureau of Labor Consumers Price Index for Wage Earners and Clerical Workers (CPI-W) for the previous **calendar year**.

Indexing is used to determine **your** percentage of lost earnings while **you** are **partially disabled**.

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**.

Last Monthly Benefit

The last Monthly Benefit Amount paid to **you** before **your** death, reduced by any Benefit Reductions, except for **disability earnings**.

Late Enrollment

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

Material and Substantial Duties

Duties that:

1. are normally required for the performance of **your regular occupation**; and
2. cannot be reasonably omitted or modified, except that if **you** are required to work an average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** are working and have the capacity to work 40 hours per week.

Maximum Capacity

Based on **your** restrictions and limitations:

1. during the first [60] months of monthly payments, the greatest extent of work **you** are able to do in **your regular occupation**; or
2. beyond [60] months of monthly payments, the greatest extent of work **you** are able to do in any occupation for which **you** are reasonably fit by education, training or experience.

Mental Illness

A psychiatric, psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the date of a **disability**. Such disorders include, but are not limited to, psychiatric, emotional or behavioral disorders, or disorders related to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a **disability**.

A **mental illness**, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purpose of the **policy**, **mental illness** does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

1. Mental Retardation;
2. Motor Skills Disorder;
3. Pervasive Development Disorders;
4. Delirium and Amnesic and other Cognitive Disorders;
5. Dementia, if it is a result of:
 - a. stroke;
 - b. trauma;
 - c. viral infection;
 - d. Alzheimer's disease; or
 - e. other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods or treatment;
6. Schizophrenia; or
7. Narcolepsy, Obstructive Sleep Apnea, and sleep disorder due to a general medical condition.

Mental Institution

A facility, including a **hospital**, that is licensed to provide care and treatment for **mental illness**.

Monthly Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the monthly average of **your** gross annual earnings prior to 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 calculated as the monthly average of **your** gross annual earnings 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 **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 calculated as the monthly average of **your** gross annual earnings 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 **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 calculated as the monthly average of **your** gross

annual earnings 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 **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 employer for the preceding **calendar year**, divided by the lesser of: (a) 12; or (b) the number of months worked.]

[For 1099 employees, **your** average 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 months 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 average **your** earnings over the number of months worked.

For sole proprietors, **your** monthly 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 average **your** earnings over 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 **your** date of **disability**; 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 disability**; 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 **your** date of **disability**.

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

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

Long Term Disability Insurance

Defined Terms

Net Monthly Benefit

Your benefit after all adjustments, including but not limited to, Benefit Reductions and **disability earnings**.

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 **monthly earnings** of 10% or more.
-

Partial Disability, Partially Disabled

While receiving **appropriate care** because of a medically determinable **injury** or **illness**;

1. **you** are performing or able to perform at least one, but not all, of the **material and substantial duties of your regular occupation** or another occupation on a full-time basis or at least one of these duties on a part-time basis, and
 2. **your disability earnings** are less than 80% of **your indexed monthly earnings** due to the same **injury** or **illness**.
-

Period of Disability

The entire time that **you** are **partially disabled** or **totally disabled**.

Any **period of disability** resulting from one or more causes will be considered a single **period of disability**.

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.

Pre-Existing Condition

Any **injury** or **illness** for which **you** have received **treatment**[,or for which an ordinarily prudent person would have received **treatment**,] at any time within the [3 months] immediately prior to the date **your coverage** or any **new coverage** became effective[,whether or not that condition is diagnosed at all or is misdiagnosed during that period of time stated in the **policy**.]

[Reasonable Accommodation]	Modifications or changes in your work environment or in a way a job is performed which allows you to perform the material and substantial duties of your job.]
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Recurrent Disability	A partial or total disability that resulted from the same or a related injury or illness as a prior partial or total disability for which a benefit was payable under the policy .
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Regular Occupation	The occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.
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Rehabilitation Program	Any employment or vocational training program in which you engage during a period of disability that is approved by us as reasonably leading to your return to active work .
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[Stand-by Help]	Active help from another person that is required to conduct activities of daily living .]
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[Terminal Illness]	A diagnosed illness that, according to generally accepted medical standards, is expected to result in death within [12] months.]
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Total Disability, Totally Disabled	<p>While receiving appropriate care because of a medically determinable injury or illness; you</p> <ol style="list-style-type: none">1. are unable to perform the material and substantial duties of your regular occupation; and2. are not being paid for performing any work or service during the Regular Occupation Period shown in the Schedule of Benefits; or3. are able to perform some but not all of the material and substantial duties of your regular occupation and your disability earnings are less than [20%] of your indexed monthly earnings due to the same injury or illness. <p>You will not be considered totally disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required license or certification to engage in the occupation.</p> <p>[After [12] months of payments, you are considered totally disabled when we review your claim and determine that, due to your illness or injury, you are</p>
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unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.]

[After [12] months of disability payments, **you** are **totally disabled** when **we** review **your** claim and determine that, due to **your illness** or **injury**:

1. **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience, and
2. a. **you** are continuously unable to perform two or more **activities of daily living (ADLs)**, without **stand-by help**; or
b. **you** have a **cognitive impairment**; or
c. **you** have a **terminal illness**.

Cognitive impairment or loss of ability to perform **ADLs** must begin on or after the date the **total disability** begins.]

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 Long Term Disability 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** Monthly Benefit 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** or any **new coverage**, **you** must satisfy the Evidence of Insurability Requirement for **your coverage** or any **new coverage** to become effective.]

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

1. **you** must satisfy the Evidence of Insurability Requirement for **your coverage** or any **new 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. for amounts **you** request to increase **your** Monthly Benefit Amount; or
4. for an increase in coverage due to an increase in **monthly earnings** of 10% or more[.][;or]
5. [for amounts for which **you** are eligible greater than the Guaranteed Maximum Benefit Amount shown in the Schedule of Benefits.]

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

Recurrent Disability

While **your coverage** is effective, successive **periods of disability** will be considered one **period of disability** unless the periods are separated by **your** return to **active work** for 6 consecutive months or more.

This provision will apply only if:

1. **your** disability resulted from the same or a related **injury** or **illness** as the prior disability; and
2. **you** have received benefits under the **policy** for the prior disability; and
3. **you** have re-enrolled for **coverage** upon return to **active work**.

Recurrent Disability will no longer apply on the earlier of:

1. the date **you** are eligible for **coverage** under any other group long term disability policy; or
2. the date this group long term disability **policy** is terminated.

Termination of your Long Term Disability 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 Continuation of Coverage during [Temporary Layoff,] **Injury, Illness** or other Leave of Absence.

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a benefit under the **policy** due to a **partial disability** or **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. **you** 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. **you** must satisfy a new **pre-existing condition** period; and
4. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

All other **policy** provisions apply.

Waiver of Premium

Premium payment for **your coverage** will be waived while **you** are receiving benefits under the **policy**.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group long term disability 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.

[We will credit the period from the date **you** were continuously insured under the Prior Plan to the date **you** become insured under the **policy** towards satisfaction of the Pre-Existing Condition Limitation under the **policy**:

1. if **you** are no longer subject to the **policy's** Pre-Existing Condition Limitation, any benefit payable under the **policy** will be paid without applying the Pre-Existing Condition Limitation; and
2. if **you** are subject to the **policy's** Pre-Existing Condition Limitation, the Prior Plan's **pre-existing condition** exclusion will be applied. The benefits **we** pay **you** under the **policy** will then be the lesser of:
 - a. the amount, if any, that **you** would have received for that condition under the Prior Plan if it had remained in effect; or
 - b. the amount that **you** would have received under the **policy**, if **you** had no **pre-existing condition**.]

[In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our policy**; or
2. the Prior Plan, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our policy**, **we** will determine **your** payments according to **our policy's** provisions.

If **you** do not satisfy the **pre-existing condition** provision of this **policy**, but **you** do satisfy the Prior Plan's **pre-existing condition** provision:

1. **your** monthly payment will be the lesser of:
 - a. the monthly payment that would have been payable under the terms of the Prior Plan if it had remained in force; or
 - b. the monthly payment under **our policy**; and
2. benefits will end on the earlier of:
 - a. the date benefits end under **our policy**, as described under the Benefit Termination provision; or
 - b. the date benefits would have ended under the Prior Plan if it had remained in force.

If **you** do not satisfy either **our policy's** or the Prior Plan's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our policy** will apply.]

[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**.]]

Conditions for Payment of Long Term Disability Benefit

We will pay **you** a long term disability benefit if **you** become **partially** or **totally disabled**, while **you** are covered under the **policy**.

We will require proof, at **your** expense, that **you** are **disabled** in order to qualify for the benefit and at reasonable intervals thereafter. At **our** expense, **we** may also require that **you** be examined by **our** choice of **physicians** and/or vocational experts. **We** may also require **you** to be interviewed by an authorized company representative.

Benefit Payment

Your Monthly Benefit Amount will be paid monthly beginning one month after the **elimination period** ends for the prior one-month period. **You** will be paid a benefit for a **period of disability** up to the maximum monthly benefit, but no less than the minimum monthly benefit. Benefits will be paid until **you** are no longer **disabled** up to the Maximum Benefit Period shown in the Schedule of Benefits.

If **you** are disabled for less than a full month, **we** will pay **you** [1/30th] of the Monthly Benefit Amount for each day of **partial disability** or **total disability**.

Benefit Termination

Benefits will stop on the earliest of the following dates:

- The date **you** are no longer **disabled** according to the **policy**;
- The date **you** reach the Maximum Benefit Period shown in the Schedule of Benefits;
- The date **you** die;
- The date **you** fail to provide proof of continuing **disability**;
- [The date **you** refuse to participate in an approved **rehabilitation program**];
- The date **your disability earnings** exceed (80%) of **your indexed monthly earnings**. If **your disability earnings** fluctuate, **we** may average **your disability earnings** over a three (3) consecutive month period of time instead of stopping **your** payment on the date **your disability earnings** reach the earnings limit;
- The date **you** cease to be under the **appropriate care** of a **physician**; or refuse to undergo, at **our** expense, an examination or testing by a **physician** or vocational, rehabilitation or health assessment testing when **we** require such examination or testing;
- The date **you** refuse to receive medical treatment, including taking prescribed medicines, that **your physician** has recommended and that is generally acknowledged to cure or improve the **illness** or **injury** for which **you** are claiming benefits under the **policy** so as to reduce its disabling effect;
- during the Regular Occupation Period when **you** are able to return to work in **your regular occupation** on a part-time basis but **you** do not;[or]
- [after the Regular Occupation Period, when **you** are able to work in any **gainful occupation** on a part-time basis but **you** do not; or]
- after 12 months of payments if **you** are considered to reside outside

the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

Determining Monthly Benefit Amount for a Total Disability

[To determine **your total disability** Monthly Benefit Amount:

1. multiply **your monthly earnings** by the benefit percentage shown in the Schedule of Benefits; and
2. take the lesser of:
 - a. the amount figured in step 1; or
 - b. the maximum monthly benefit shown in the Schedule of Benefits; and then
3. subtract the amount of Benefit Reductions.

]

[To determine **your total disability** Monthly Benefit Amount:

1. multiply **your basic monthly earnings** by the benefit percentage shown in the Schedule of Benefits; and
2. take the lesser of:
 - a. the amount figured in step 1; or
 - b. [70%] of **your basic monthly earnings** less the other income benefits shown under Benefit Reductions; or
 - c. the maximum monthly benefit shown in the Schedule of Benefits]

The monthly benefit will never be less than the minimum monthly benefit shown in the Schedule of Benefits.

Work Incentive Benefit

[During the first [12] months of benefit payments for **your partial disability, your**][**Your**] Monthly Benefit Amount for **your partial disability** will be based on the **total disability** Monthly Benefit Amount for a **total disability**, but will not be reduced by any **disability earnings you** receive until **your** Monthly Benefit amount plus **your disability earnings** exceed 100% of **your indexed monthly earnings**. If **your** Monthly Benefit Amount plus **your disability earnings** exceed 100% of **your indexed monthly earnings**, we will subtract the amount of earnings over 100% from **your** Monthly Benefit Amount. Any employment under this provision must be approved by **us** as reasonably leading to **your** return to **active work**.

If **we** do not approve a Work Incentive Benefit [or an approved Work Incentive Benefit exceeds the [12] month benefit payment period], **your partial disability** will be determined as described in the Determining Monthly Benefit Amount for a Partial Disability provision.

Determining Monthly Benefit Amount for a Partial Disability

To determine **your partial disability** Monthly Benefit Amount:

1. subtract any **disability earnings** from **your indexed monthly earnings**; and
2. divide the amount figured in step 1 by **your indexed monthly earnings**; and then
3. multiply the amount figured in step 2 by **your total disability** Monthly Benefit Amount as determined above.

The monthly benefit will never be less than the minimum monthly benefit shown in the Schedule of Benefits.

[Benefit Reductions

Your long term disability benefit will be reduced by income from any of the following sources that **you** receive or are eligible to receive as a result of **your [partial disability or] total disability** or retirement:

1. MISCELLANEOUS BENEFITS. Benefits for which **you** are eligible under:
 - a. any unemployment compensation law; or
 - b. [any occupational disease law]; or
 - c. any state compulsory benefit act or law; or
 - d. [any workers' compensation law; or]
 - e. any other law of similar intent.
2. MOTOR VEHICLE DISABILITY BENEFITS. Benefits for which **you** are eligible under the mandatory portion of any "no fault" motor vehicle plan, or any other law of similar intent.
3. SOCIAL SECURITY BENEFITS. Any benefits that **you** receive or are eligible to receive as disability payments or as retirement payments under the United States Social Security Act or any other country's equivalent of that act. [**We** will also reduce **your** benefit payment by any amount that **your** spouse or children receive or are eligible to receive under any of these acts, as payments because of your disability or retirement.]

We will not reduce **your** payment by **your** Social Security Retirement income if **your** disability begins after **your** Social Security Normal Retirement date and **you** are already receiving Social Security Retirement payments.

4. DISABILITY INCOME BENEFITS: Any disability income benefits that **you** receive under any group insurance plan of the **covered employer** or any employer, any government retirement system related to **your** employment with the **covered employer**, any formal or informal salary continuation or sick leave program of the **covered employer**.
- [5. [1099 INCOME:]Any amount **you** receive as income from any form of employment, including but not limited to renewal commissions and residual sales commissions.]

6. OTHER INCOME. Any amount **you** receive as income replacement from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
7. RETIREMENT BENEFITS. Retirement benefits from a plan sponsored by the **covered employer** or any state or federal government.

RETIREMENT BENEFITS: Reference to "retirement benefits" is limited to employer sponsored benefits that:

1. do not represent contributions that **you** made (payments that represent **your** contributions are deemed to be received over **your** expected remaining lifetime, regardless of when those payments are actually received); and
2. are payable upon:
 - a. early or normal retirement after **your** disability begins; or
 - b. disability, provided the payment does not reduce the amount of benefits that would have been paid by the plan at **your** normal retirement age.

ESTIMATING BENEFITS: **We** reserve the right to reduce **your** Monthly Benefit Amount by estimating Social Security benefits, state compulsory benefits and Workers' Compensation benefits. **We** will not reduce **your** Monthly Benefit Amount by these estimated benefits if **we** receive proof that **you** have applied for these benefits and **you** have signed an agreement to repay any overpayment and to allow **us** to obtain information on awards directly from the appropriate state or federal agency. When **we** receive proof of approval or final denial (meaning **you** have exhausted all appeals for these benefits), **we** will adjust **your** Monthly Benefit Amount and notify **you** of any refund to **us** required by **you** based on any overpayments.

In any case where **we** have reduced **your** Monthly Benefit Amount by estimated benefits, **we** will adjust **your** payment when **we** receive proof of the denial or of the actual amount **you** have received. **We** will make a lump sum refund of any benefits due at that time.

LUMP SUM PAYMENTS: Benefit Reductions that are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum was paid or, if less, the **policy's** applicable Maximum Benefit Period. If no time period is stated, the sum will be prorated over **your** expected lifetime as determined by **us**, using appropriate actuarial tables.

COST OF LIVING FREEZE: **We** will not reduce **your** Monthly Benefit Amount by any increase in the amount of Benefit Reductions **you** receive from any source, except earnings from any form of employment, if the Benefit Reduction changes because of a cost of living increase that occurs automatically at any time after **you** satisfy the **elimination period**.

SOURCES OF INCOME THAT DO NOT REDUCE BENEFITS: **We** will not subtract from **your** gross disability benefit, income **you** receive from the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. non-qualified plans of deferred compensation;
7. pension plans for partners;
8. military pension and disability income plans;
9. credit disability insurance;
10. franchise disability income plans;
11. no fault automobile insurance plans, except where required by law;
12. individual disability plans paid by the employee;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).]

Survivor Benefit

We will pay a benefit to **your eligible survivor** if **we** receive proof that **your** death occurred:

1. while **you** were receiving or were eligible to receive payments for a **period of disability**; and
2. **your period of disability** had continued for 180 or more consecutive days.

This benefit will be a lump sum benefit equal to [3 times] **your last monthly benefit**.

We will first apply the Survivor Benefit to any overpayment which may exist on **your** claim.

If **you** have no **eligible survivors**, this benefit will be payable to **your** estate, unless there is none. In this case, no payment will be made.

[Advanced Survivor Benefit

You may receive **your** Survivor Benefit prior to **your** death if **you** have been diagnosed with a **terminal illness**.

We will pay **you** a lump sum amount equal to [3] months of **your last monthly benefit** if:

1. **your disability** had continued for [180] or more consecutive days; and
2. **you** have been diagnosed with a **terminal illness**; and
3. **you** are receiving or are eligible to receive monthly payments under the **policy**.

We will first apply the Advanced Survivor Benefit to recover any overpayment which may exist on **your** claim.

This benefit is available to **you** on a voluntary basis and will be payable one time only under the **policy**.

Your right to exercise this option and receive payment is subject to the following;

1. **you** must make this election in writing to **us**; and
2. **your physician** must certify in writing that **you** have a **terminal illness**.

If **you** receive this benefit prior to **your** death, no Survivor Benefit will be payable upon **your** death.]

[Child Care Expense Benefit

This provision applies during the first 30 months following the date **you** have satisfied the **elimination period**.

After the 4th week of **disability** following the **elimination period**, when **you** work or participate in a **rehabilitation program** approved by **us**, **you** will be reimbursed for Child Care Expenses for each Eligible Child.

“Child Care Expenses” mean the monthly expenses, up to [\$250] for each Eligible Child and not to exceed [\$1000] per month, charged by a licensed childcare provider. The childcare provider may not be a member of **your** immediate family or living in **your** residence. **You** must provide satisfactory proof to **us** that **you** incurred such charges.

This benefit will cease on the earlier of:

1. 30 months following the date **you** have satisfied the **elimination period**; or
2. the end of **your rehabilitation program**.

“Eligible Child” is **your** dependent child under age 13 who lives with **you** and is **your** child or **your** spouse’s child.

The term “child” includes natural, adopted, foster, or stepchild. An “adopted child” is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued.]

[Cost of Living Adjustment Benefit

We will make a cost of living adjustment to **your** Monthly Benefit Amount after **you** have received [[6] months of monthly benefit payments][[one] full year[s] of monthly benefit payments]]. In order to qualify for this benefit, **you** must be receiving benefits under the **policy** on the [next following anniversary of **your** first benefit payment]. Additional adjustments will be applied on [each subsequent anniversary] that **your partial disability** or **total disability** continues [up to [5] adjustments] in any one **period of disability**.

To determine **your** Monthly Benefit Amount after a cost of living adjustment:

1. multiply **your** current Monthly Benefit Amount by the lesser of;
 - a. [2%]; or
 - b. 2/3 of the percentage increase in the U.S. Bureau of Labor Consumer Price Index for Wage Earners and Clerical Workers (CPI_W) for the previous **calendar year**; and
2. add the amount figured in step 1 to **your** Monthly Benefit Amount. The resulting amount will not be subject to the maximum monthly benefit shown in the Schedule of Benefits. For the purpose of calculating these adjustments, **your** Monthly Benefit Amount will include any prior year's cost of living adjustment.]

[Medical or COBRA Premium Disability Benefit

If **you** are **disabled** and receiving a monthly benefit for **disability** under the **policy**, **you** may be eligible to receive an additional Medical or COBRA Premium Disability Benefit.

This Medical or COBRA Premium Disability Benefit is subject to all other provisions of the **policy** other than as stated in this section.

Medical or COBRA Premium Disability Benefits are payable for **you** if **you** meet all of the following requirements:

1. **you** are insured under the **policy**;
2. **you** are **disabled** according to the terms of the **policy**;
3. **you** are receiving or are eligible to receive a monthly benefit for **disability** under the **policy**; and
4. **you** are paying premiums for medical coverage or COBRA Medical Coverage under **your covered employer's** plan.

Benefits under this provision will begin the day after **you** satisfy all of the above requirements.

We will pay **you** an additional monthly benefit, equal to the lesser of:

1. the amount of the monthly premium **you** are paying for yourself only, for medical coverage or COBRA Medical Coverage, or
2. [\$500].

Your Medical or COBRA Premium Disability Benefit will not be reduced by any Benefit Reductions listed in the **policy**.

If **you** are eligible to receive a Medical or COBRA Premium Disability Benefit for less than 1 month, **we** will send **you** 1/30th of **your** payment for each day **you** are **disabled**.

The Medical or COBRA Premium Disability benefit will terminate the earliest of the following:

1. the date **you** are no longer receiving or are no longer eligible to receive a monthly benefit for **disability** under the **policy**;
2. the date **you** are no longer **disabled** under the terms of the **policy**;
3. the date **you** have received [18 -24]months of Medical or COBRA Premium Disability payments, for a combination of medical coverage and COBRA Medical Coverage;
4. the last day **you** are covered for medical coverage, or COBRA Medical Coverage;
5. the last day of the period for which **you** qualify for COBRA Medical Coverage; or
6. the date **you** failed to give **us** the required proof that **you** are paying premiums for medical coverage or COBRA Medical Coverage.

“COBRA” means the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 and any subsequent amendments.

“COBRA MEDICAL COVERAGE” means the continuation of Medical Coverage under the Employer’s plan as provided for under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

“MEDICAL COVERAGE” means coverage provided under the Employer’s health or medical plan that pays for **your** medical, hospital, or surgical expenses.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

If **you** suffer an **injury** that results in any of the losses shown below within 90 days of the date of the accident, **we** will pay **you** the Monthly Benefit Amount for the number of months shown below.

Payment of this benefit will not be subject to satisfying the **elimination period**. However, after the **elimination period** has been completed, this benefit will be paid in lieu of the regular monthly payment, not in addition to it. If **you** remain **disabled** beyond the number of monthly payments under this provision, benefits may continue as provided under the **policy**. The months **you** receive benefits under this provision will be excluded in computing the number of months **you** receive payments for **disability** and in computing any remaining **Maximum Benefit Period** for **disability**. If **you** die, this benefit will cease.

FOR LOSS OF: PAYMENTS:	NUMBER OF MONTHLY
Sight of Both Eyes	46
Both Hands	46
Both Feet	46
One Hand and One Foot	46
One Hand and Sight of One Eye	46
One Foot and Sight of One Eye	46
One Hand or One Foot	23

Sight of One Eye	23
Thumb and Index Finger of Either Hand	12

The maximum number of monthly payments for all losses suffered in any one accident shall be limited to that one loss for which the greatest number of monthly payments is provided in the above schedule.

Loss of hands and feet means loss by severance at or above the wrist or ankle joint. Loss of sight means legal blindness. Loss of thumb and index finger means actual severance at or above the knuckles joining each hand.]

[Pension Contribution Benefit

If **you** become **totally disabled** and **you** qualify for a long term disability benefit and have participated in the **covered employer's** pension plan for at least 3 months before **you** became **totally disabled**, then **you** may be eligible to receive an additional benefit.

This additional benefit will equal the amount **you** were contributing toward the pension plan as of the date of **your total disability**, but will not be more than [6%] of **your monthly earnings**.

We will pay this additional benefit to the Plan Administrator for deposit into the pension plan on **your** behalf.

We will stop paying this benefit on the earlier of:

1. the date **you** are no longer **totally disabled**; or
2. the date **you** return to any occupation; or
3. the date **you** stop participating in **your covered employer's** pension plan; or
4. the date **you** stop receiving **total disability** payments from **us** under the **policy**.]

[Progressive Income Benefit

We will pay **you** an additional benefit equal to [10%] of **your monthly earnings**, not to exceed [\$3,000] per month, if **you** are unable to perform the **material and substantial duties** of **your regular occupation** due to **your injury** or **illness**, and **you**:

1. are continuously not able to perform two or more **activities of daily living** without **stand-by help**; or
2. have a **cognitive impairment**; or
3. have a **terminal illness**.

Activities of daily living you are not able to perform, without **stand-by help**, prior to the effective date of **your coverage** will not be covered.

This additional benefit will terminate when **you** are able to continuously perform all of the **activities of daily living** without **stand-by help**. This does not include an **activity of daily living you** were not able to perform prior to **your effective date of coverage**.]

[Reasonable Accommodation Expense Benefit

If **you** return to work in any occupation for any employer, not including self-employment, as a result of a **reasonable accommodation** made by such employer, **we** will pay that employer a Reasonable Accommodation Expense Benefit up to the lesser of [\$1,000] or the equivalent of [2] months of **your** monthly benefit; but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the **reasonable accommodation** is approved by **us** in writing prior to its implementation. This benefit is available to **you** one time while **you** are insured under the **policy**.]

[Spouse and Elder Care Expense Benefit

This provision applies during the first 30 months following the date **you** have satisfied the **elimination period**.

After the 4th week of **disability** following the **elimination period**, when **you** work or participate in a **rehabilitation program** approved by **us**, **you** will be reimbursed for Eligible Spouse and Elder Care Expenses for each Eligible Family Member.

“Eligible Spouse and Elder Care Expenses” are the monthly expenses, up to [\$250] for each Eligible Family Member and not to exceed a maximum of [\$1,000] per month, **you** incur for the care of **your** Eligible Family Member that are:

1. charged by a licensed adult care provider; who is not a member of **your** immediate family or living in **your** residence; and
2. documented by receipts from the licensed adult care provider which includes the provider's social security number or taxpayer identification number.

Eligible Spouse and Elder Care Expenses do not include expenses for which **you** are eligible for reimbursement under any other group plan or from any other source.

This benefit will cease on the earlier of:

1. 30 months following the date **you** have satisfied the **elimination period**; or
2. the end of **your rehabilitation program**.

“Eligible Family Member ” is:

1. **your** spouse;
2. **your** parents and grandparents; and
3. **your** spouse's parents and grandparents.

An Eligible Family Member must be:

1. incapable of caring for himself or herself as a result of a mental or physical impairment;
2. living with **you** as part of **your** household; and
3. chiefly dependent on **you** for support.

You must provide satisfactory proof to **us** that the Eligible Family Member is incapable of caring for himself or herself and is chiefly dependent on **you** for support.]

[401(k) Contribution Benefit

If **you** become **totally disabled** and **you** qualify for a long term disability benefit and have participated in the **covered employer's** 401(k) plan for at least 3 months before **you** became **totally disabled**, then **you** may be eligible to receive an additional benefit.

This additional benefit will equal the amount **you** were contributing toward the 401(k) plan as of the date of **your total disability**, but will not be more than [6%] of **your monthly earnings**.

We will pay this additional benefit to the Plan Administrator for deposit into the 401(k) plan on **your** behalf.

We will stop paying this benefit on the earlier of:

1. the date **you** are no longer **totally disabled**; or
 2. the date **you** return to any occupation; or
 3. the date **you** stop participating in **your covered employer's** 401(k) plan; or
 4. the date **you** stop receiving **total disability** payments from **us** under the **policy**.]
-

[Mental Illness Limitation

Not more than [24] monthly benefit payments will be made [during **your** lifetime][per occurrence] for any **period of disability** due to **mental illness**, unless **you** are an inpatient at a **mental institution** or **hospital** at the end of that [24] months. In that event, monthly benefits will be paid while **your** confinement continues.

If **you** are still **disabled** when **you** are discharged, monthly benefits will continue during **your period of disability** for a recovery period of up to 90 days. During that 90-day recovery period, if **you** are again confined in a **mental institution** or **hospital** for a period of at least 14 consecutive days, benefits will continue during the **period of disability** while **you** remain confined and for another recovery period of 90 days.

In no event will monthly benefit payments for any one **period of disability** exceed the Maximum Benefit Period shown in the Schedule of Benefits.]

[Alcohol and Drug Abuse Limitation

Not more than [24] monthly benefit payments will be made [during **your** lifetime][per occurrence] for any **period of disability** due to alcohol and/or drug abuse, unless **you** are an inpatient at a **hospital, institution** or rehabilitation center at the end of that [24] months receiving **treatment** for the alcohol and/or drug abuse. In that event, monthly benefits will be paid while **your** confinement continues.

If **you** are still **disabled** when **you** are discharged, monthly benefits will continue during **your period of disability** for a recovery period of up to 90 days. During that 90-day recovery period, if **you** are again confined in a **hospital, institution** or rehabilitation center and receiving **treatment** for the alcohol and/or drug abuse for a period of at least 14 consecutive days, benefits will continue during the **period of disability** while **you** remain confined and for another recovery period of 90 days.

In no event will monthly benefit payments for any one **period of disability** exceed the Maximum Benefit Period shown in the Schedule of Benefits.]

[Special Conditions Limitation

We pay only a limited benefit for a **period of disability** due to Special Conditions. The Maximum Benefit Period [for all such **periods of disability**][per occurrence] is [24] months [during **your** lifetime]. [This is not a separate maximum for each such condition, or for each **period of disability**, but a combined maximum for all **periods of disability** and for all of these conditions.]

Your period of disability will be considered due to Special Conditions if:

1. **you** are limited by one or more of the stated conditions; and
2. **you** do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit **your** activities, and lead **us** to conclude that **you** were **disabled**.

Benefits may be payable for more than [24] months, but not beyond the

Maximum Benefit Period in the Schedule of Benefits, if **you**:

1. are **hospital confined** at the end of the [24] month period above, and
2. remain **disabled**.

Benefits will be payable for the length of **your** confinement and for up to 90 days following the end of **your** confinement.

If **you** are **hospital confined** again during the 90-day period for at least 14 consecutive days, benefits will be payable for the length of the second confinement and for up to 90 days following the end of the second confinement.

Special Conditions means:

1. **Mental Illness**;
2. Musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, except:
 - a. arthritis;
 - b. herniated intervertebral discs;
 - c. scoliosis;
 - d. spinal fractures;
 - e. osteopathies;
 - f. spinal tumors, malignancy, or vascular malformations;
 - g. radiculopathies, documented by electromyogram;
 - h. spondylolisthesis, grade II or higher;
 - i. myelopathies and myelitis;
 - j. demyelinating disease;
 - k. traumatic spinal cord neurosis;
 - l. myofacial pain syndrome; or
 - m. shoulder sprains and strains;
3. Chronic fatigue syndrome;
4. Fibromyalgia;
5. Carpal Tunnel Syndrome;
6. Environmental allergic **illness**, including but not limited to sick building syndrome and multiple chemical sensitivity; or
7. Alcohol, drug or chemical abuse, dependency or addiction.]

Pre-Existing Condition Limitation

We will not pay **you** the Monthly Benefit Amount for a **partial disability** or **total disability** that is both:

1. caused by, attributed to, or that results, in whole or in part, from a **pre-existing condition**; and
2. begins in the first [12 months] after the effective date of **your coverage** or any **new coverage** under the **policy** [unless **you** have

Limitations and Exclusions

been **treatment** free for [12] consecutive months after **your** effective date of **coverage**].

If **your** benefits under the **policy** are increased, **you** will not be paid the increased benefit amount (but **you** will receive the benefit in effect prior to the increase) for any **disability** caused by, attributed to, or that results, in whole or in part, from a **pre-existing condition** that begins in the first [12 months] after the increase became effective [unless **you** have been **treatment** free for [12] consecutive months after the increase became effective].

Exclusions

The **policy** will not cover any **period of disability** caused by, attributed to, or resulting from **your**:

1. elective procedure or surgery; or
2. engaging in any illegal or fraudulent occupation, work, or employment; or
3. traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes; or
4. participation in a war, or an act of war, declared or undeclared or any act of war; or
5. active military duty; or
6. active participation in a riot, rebellion or insurrection; or
7. attempting to commit, or committing, or participating in, an assault or felony; or
8. commission of a crime for which **you** have been convicted; or
9. intentionally self-inflicted **injury** or **illness**, while sane or insane; or
10. attempted suicide, while sane or insane[.]; or]
11. [being legally intoxicated[.]; or]
12. [being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **physician**[.]; or]
13. [occupational **illness** or **injury**, which is an **illness** or **injury** caused by or aggravated by any employment for pay or profit.]

We will not pay any benefits for any period that **you** are confined to any facility because **you** were convicted of a crime or other illegal act.

Notice

We encourage **you** to notify **us** of **your** claim 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 the **injury** or **illness** begins, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of an **injury** or **illness**.

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

Proof of Loss

You must send **us** a proof of loss within 90 days after the end of the **elimination period**.

We will not decline or reduce a claim if: (a) it is not reasonably possible to give proof within that time; and (b) the proof is submitted within one year from the date of loss or incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**. **Your** proof of loss must show:

1. that **you** are under the **appropriate care** of a **physician**; and
2. the date **your disability** began; and
3. the cause of **your disability**; and
4. the appropriate documentation of **your monthly earnings** and **your activities**; and
5. the extent of **your disability**, including restrictions and limitations preventing **you** from performing **your regular occupation**; and
6. the name and address of any **hospital** or **institution** where **you** received **treatment**, including all attending **physicians**; and
7. documentation of prior disability coverage if applicable.

We may request that **you** send proof of continuing **disability** indicating that **you** are under the continuous care and **treatment** of a **physician**. This proof, provided at **your** expense, must be received within 30 days of a request by **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**. All benefits to which **you** are entitled will be paid monthly during **your period of disability**. Any balance remaining unpaid at the end of that period will be paid as soon as possible after **we** receive the proof of loss.

Payment of Claims

All 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.

Claims for loss of life will be paid according to the Survivor Benefit provision in the Long Term Disability Benefit section.

Legal Actions

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

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were 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** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180] days after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [45] days after **we** receive **your** 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 **you** 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.

Recovery and Subrogation

When **your** injury or illness appears to be someone else's fault, any benefits otherwise due under the **policy** for a resulting **period of disability** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Voluntary Long Term Disability Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[06/01/2010]
Plan Effective Date	[06/01/2010]
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	For your 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 premium for your coverage .] [You are required to contribute towards the cost of your coverage .]
Your Monthly Benefit Amount	[Your Monthly Benefit Amount will be equal to the lesser of: 1. [60%] of your monthly earnings ; or 2. [\$3,000] maximum monthly benefit, minus any income listed in Benefit Reductions.] [At least [\$500] per month, elected in [\$100] increments, not to exceed [40%] of your monthly earnings , up to a maximum benefit of [\$1000]. [After applying the Benefit Reductions, the minimum monthly benefit will be [the greater of: (a) [10%] of your Monthly Benefit Amount; or (b)] [\$100].] [Guarantee Maximum Benefit Amount: [\$3,000]] [Monthly Benefit Amounts in excess of the guarantee maximum benefit amount will be subject to our approval of your evidence of insurability .]

Voluntary Long Term Disability Insurance

Schedule of Benefits

Residual Disability Benefit [Included. The **Elimination Period** can be satisfied with days of **partial** or **total disability**.] [Not Included.]

Elimination Period [The later of] [90 days] [or the end of **your** accumulated sick leave with the **covered employer**.]

Regular Occupation Period [[24 months] of benefit payments.] [Duration of the Maximum Benefit Period.]

Maximum Benefit Period	[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
	under age 60	to your normal retirement age
	age 60	to your normal retirement age, but not less than 60 months
	age 61	to your normal retirement age, but not less than 48 months
	age 62	to your normal retirement age, but not less than 42 months
	age 63	to your normal retirement age, but not less than 36 months
	age 64	to your normal retirement age, but not less than 30 months
	age 65	24 months
	age 66	21 months
	age 67	18 months
	age 68	15 months
	age 69 or older	12 months

Your normal retirement age is **your** retirement age based on the 1983 amendment to the Social Security Act where retirement age depends on **your** year of birth, as follows:

YEAR OF BIRTH	SOCIAL SECURITY NORMAL RETIREMENT AGE:
1937 or before	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 & after	67 years]

Voluntary Long Term Disability Insurance

Schedule of Benefits

[ATTAINED AGE WHEN
DISABILITY BEGINS:

under age 67
ages 67 through 69
age 70 and older

MAXIMUM BENEFIT PERIOD:

3 years
to age 70 but not less than 1 year
1 year]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

under age 68
ages 68 through 69
age 70 and older

MAXIMUM BENEFIT PERIOD:

2 years
to age 70 but not less than 1 year
1 year]

[ATTAINED AGE WHEN
DISABILITY BEGINS:

Under age 61

age 61

age 62

age 63

age 64

age 65

age 66

age 67

age 68

age 69 or older

MAXIMUM BENEFIT PERIOD:

to **your** normal retirement age, but not less than 60 months

to **your** normal retirement age, but not less than 48 months

to **your** normal retirement age, but not less than 42 months

to **your** normal retirement age, but not less than 36 months

to **your** normal retirement age, but not less than 30 months

24 months

21 months

18 months

15 months

12 months

Your normal retirement age is **your** retirement age based on the 1983 amendment to the Social Security Act where retirement age depends on **your** year of birth, as follows:

YEAR OF BIRTH

SOCIAL SECURITY NORMAL RETIREMENT AGE:

1937 or before

65 years

1938

65 years, 2 months

1939

65 years, 4 months

1940

65 years, 6 months

1941

65 years, 8 months

1942

65 years 10 months

1943-1954

66 years

1955

66 years, 2 months

1956

66 years, 4 months

1957

66 years, 6 months

1958

66 years, 8 months

1959

66 years, 10 months

1960 & after

67 years]

Voluntary Long Term Disability Insurance

Schedule of Benefits

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 61	60 months
age 61	48 months
age 62	42 months
age 63	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 64	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 66	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 60	age 65
age 60	60 months
age 61	48 months
age 62	42 months
age 63	36 months
age 64	30 months
age 65	24 months
age 66	21 months
age 67	18 months
age 68	15 months
age 69 or older	12 months]

[ATTAINED AGE WHEN

Voluntary Long Term Disability Insurance

Schedule of Benefits

DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 60	to age 65
ages 60 through 64	5 years
ages 65 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 70	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 60	10 years
ages 60 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]

[ATTAINED AGE WHEN DISABILITY BEGINS:	MAXIMUM BENEFIT PERIOD:
under age 65	5 years
ages 65 through 69	to age 70 but not less than 1 year
age 70 and older	1 year]

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.]

Injury or Illness – 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).

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).

Survivor Benefit	Included.
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[Advanced Survivor Benefit	Included.]
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[Child Care Expense Benefit	Included.]
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[Cost of Living Adjustment Benefit	Included.]
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Voluntary Long Term Disability Insurance

Schedule of Benefits

[Medical or COBRA Premium Disability Benefit	Included.]
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[Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Included.]
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[Pension Contribution Benefit	Included.]
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[Progressive Income Benefit	Included.]
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[Reasonable Accommodation Expense Benefit	Included.]
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[Spouse and Elder Care Expense Benefit	Included.]
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[401(k) Contribution Benefit	Included.]
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[Alcohol and Drug Abuse Limitation	Included.]
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[Mental Illness Limitation	Included.]
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[Special Conditions Limitation	Included.]
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Voluntary Long Term Disability Insurance

Defined Terms

[Activities of Daily Living (ADL)]

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).]

Appropriate Care

You:

1. regularly visit a **physician** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s); and
2. receive care or **treatment** appropriate for the disabling condition(s), conforming with standard medical practice, by a **physician** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize **your** disabling condition including corrective **treatment** or minor surgery.

[Cognitive Impairment]

A deterioration or loss in **your** intellectual capacity, resulting from **injury, illness, Alzheimer's disease** or similar forms of irreversible dementia that results in **your** needing another person's continuous active help or verbal guidance for **your** own protection or for the protection of others. Determination of the deterioration or loss will be based on clinical evidence and/or clinical tests, according to generally accepted medical standards, that reliably measure **your** impairment.

No benefits are provided for **cognitive impairments** that begin prior to the date **you** become a **covered person**.]

Disability, Disabled

Total Disability or **Partial Disability** and **Totally Disabled** or **Partially Disabled**.

Disability Earnings

The earnings which **you** receive while **you** are **disabled** and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

Eligible Survivor

Your spouse, if living; otherwise **your** children under age 25. Any payment due **your** children will be paid in equal shares. Payment may be made to a

Voluntary Long Term Disability Insurance

Defined Terms

person named by **us** to receive the payment on **your** children's behalf. This payment will be valid against all claims by others representing or claiming to represent the children.

Elimination Period

The initial number of consecutive days of a **period of disability** for which no benefit is payable under the **policy**.

We will count only those days **you** are **totally disabled** to satisfy the **elimination period**. If a Residual Disability Benefit is included as shown in the Schedule of Benefits, **we** will also include those days that **you** are **partially disabled**. If **you** return to work full-time for no more than [14] **calendar days** during the **elimination period**, **we** will treat the **disability** as continuous. The Elimination Period is shown in the Schedule of Benefits.

Evidence of Insurability

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

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

Gainful Occupation

An occupation that is or can be expected to provide **you** with an income within 12 months of **your** return to work, that exceeds:

1. [80%] of **your indexed monthly earnings**, if **you** are working; or
2. [60%] of **your indexed monthly earnings**, if **you** are not working.

Gross Monthly Benefit

Your benefit before adjustments for Benefit Reductions and **disability earnings**.

Hospital, Health Facility or Institution

An accredited facility licensed to provide care for the condition causing **your disability**.

Hospital Confined

You are confined as an in-patient in a **hospital, health facility or institution**.

Illness

Your medically determinable sickness, disease or pregnancy.

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

Indexed Monthly Earnings

Your monthly earnings, as adjusted on the first anniversary of benefit payments and each anniversary thereafter. To adjust **your monthly earnings**, **we** will add the lesser of the following to **your monthly earnings**:

1. 10% of **your monthly earnings**; or

Voluntary Long Term Disability Insurance

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2. the annual percentage increase in the U.S. Bureau of Labor Consumers Price Index for Wage Earners and Clerical Workers (CPI-W) for the previous **calendar year**.

Indexing is used to determine **your** percentage of lost earnings while **you** are **partially disabled**.

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**.

Last Monthly Benefit

The last Monthly Benefit Amount paid to **you** before **your** death, reduced by any Benefit Reductions, except for **disability earnings**.

Late Enrollment

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

Material and Substantial Duties

Duties that:

1. are normally required for the performance of **your regular occupation**; and
2. cannot be reasonably omitted or modified, except that if **you** are required to work an average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** are working and have the capacity to work 40 hours per week.

Maximum Capacity

Based on **your** restrictions and limitations:

1. during the first [60] months of monthly payments, the greatest extent of work **you** are able to do in **your regular occupation**; or
2. beyond [60] months of monthly payments, the greatest extent of work **you** are able to do in any occupation for which **you** are reasonably fit by education, training or experience.

Mental Illness

A psychiatric, psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the date of a **disability**. Such disorders include, but are not limited to, psychiatric, emotional or behavioral disorders, or disorders related to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a **disability**.

A **mental illness**, as so defined, may be related to or be caused by physical or

biological factors, or result in physical symptoms or expressions. For the purpose of the **policy**, **mental illness** does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

1. Mental Retardation;
2. Motor Skills Disorder;
3. Pervasive Development Disorders;
4. Delirium and Amnesic and other Cognitive Disorders;
5. Dementia, if it is a result of:
 - a. stroke;
 - b. trauma;
 - c. viral infection;
 - d. Alzheimer's disease; or
 - e. other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods or treatment;
6. Schizophrenia; or
7. Narcolepsy, Obstructive Sleep Apnea, and sleep disorder due to a general medical condition.

Mental Institution

A facility, including a **hospital**, that is licensed to provide care and treatment for **mental illness**.

Monthly Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the monthly average of **your** gross annual earnings prior to 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 calculated as the monthly average of **your** gross annual earnings 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 **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 calculated as the monthly average of **your** gross annual earnings 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 **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 calculated as the monthly average of **your** gross annual earnings 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 **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 employer for the preceding **calendar year**, divided by the lesser of: (a) 12; or (b) the number of months worked.]

[For 1099 employees, **your** average 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 months 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 average **your** earnings over the number of months worked.

For sole proprietors, **your** monthly 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 average **your** earnings over 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 **your** date of **disability**; 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 disability**; 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 **your** date of **disability**.

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

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

Voluntary Long Term Disability Insurance

Defined Terms

Net Monthly Benefit

Your benefit after all adjustments, including but not limited to, Benefit Reductions and **disability earnings**.

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 **monthly earnings** of 10% or more.
-

Partial Disability, Partially Disabled

While receiving **appropriate care** because of a medically determinable **injury** or **illness**;

1. **you** are performing or able to perform at least one, but not all, of the **material and substantial duties of your regular occupation** or another occupation on a full-time basis or at least one of these duties on a part-time basis, and
 2. **your disability earnings** are less than 80% of **your indexed monthly earnings** due to the same **injury** or **illness**.
-

Period of Disability

The entire time that **you** are **partially disabled** or **totally disabled**.

Any **period of disability** resulting from one or more causes will be considered a single **period of disability**.

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.

Pre-Existing Condition

Any **injury** or **illness** for which **you** have received **treatment**[,or for which an ordinarily prudent person would have received **treatment**,] at any time within the [3 months] immediately prior to the date **your coverage** or any **new coverage** became effective[,whether or not that condition is diagnosed at all or is misdiagnosed during that period of time stated in the **policy**].

Voluntary Long Term Disability Insurance

Defined Terms

[Reasonable Accommodation	Modifications or changes in your work environment or in a way a job is performed which allows you to perform the material and substantial duties of your job.]
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Recurrent Disability	A partial or total disability that resulted from the same or a related injury or illness as a prior partial or total disability for which a benefit was payable under the policy .
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Regular Occupation	The occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.
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Rehabilitation Program	Any employment or vocational training program in which you engage during a period of disability that is approved by us as reasonably leading to your return to active work .
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[Stand-by Help	Active help from another person that is required to conduct activities of daily living .]
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[Terminal Illness	A diagnosed illness that, according to generally accepted medical standards, is expected to result in death within [12] months.].
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Total Disability, Totally Disabled	<p>While receiving appropriate care because of a medically determinable injury or illness; you</p> <ol style="list-style-type: none">1. are unable to perform the material and substantial duties of your regular occupation; and2. are not being paid for performing any work or service during the Regular Occupation Period shown in the Schedule of Benefits; or3. are able to perform some but not all of the material and substantial duties of your regular occupation and your disability earnings are less than [20%] of your indexed monthly earnings due to the same injury or illness. <p>You will not be considered totally disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required license or certification to engage in the occupation.</p> <p>[After [12] months of payments, you are considered totally disabled when we review your claim and determine that, due to your illness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably qualified based on your training, education and experience.]</p>
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Voluntary Long Term Disability Insurance

Defined Terms

[After [12] months of **disability** payments, **you** are **totally disabled** when we review **your** claim and determine that, due to **your illness** or **injury**:

1. **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience, and
2.
 - a. **you** are continuously unable to perform two or more **activities of daily living (ADLs)**, without **stand-by help**; or
 - b. **you** have a **cognitive impairment**; or
 - c. **you** have a **terminal illness**.

Cognitive impairment or loss of ability to perform **ADLs** must begin on or after the date the **total disability** begins.]

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 Long Term Disability Insurance

Long Term Disability Coverage

Effective Date of your Long Term Disability 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 first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.]

Increases or decreases in **your** Monthly Benefit 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** or any **new 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** or any **new 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 a **late enrollment**; or
2. if **you** voluntarily terminated **your coverage** and are re-enrolling; or
3. if **you** apply to increase **your** monthly benefit by any amount during the policy year; or
4. for amounts for which **you** are eligible greater than the guaranteed maximum benefit as shown in the Schedule of Benefits.

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

Recurrent Disability

While **your coverage** is effective, successive periods of disability will be considered one **period of disability** unless the periods are separated by **your** return to **active work** for 6 consecutive months or more.

This provision will apply only if:

1. **your** disability resulted from the same or a related **injury** or **illness** as the prior disability; and
2. **you** have received benefits under the **policy** for the prior disability; and
3. **you** have re-enrolled for **coverage** upon return to **active work**.

Recurrent Disability will no longer apply on the earlier of:

1. the date **you** are eligible for **coverage** under any other group long term disability policy; or
2. the date this group long term disability **policy** is terminated.

Termination of your Long Term Disability Coverage

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

Voluntary Long Term Disability Insurance

Long Term Disability Coverage

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

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a benefit under the **policy** due to a **partial disability** or **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. **you** 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. **you** must satisfy a new **pre-existing condition** period; and
4. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

All other policy provisions apply.

Waiver of Premium

Premium payment for **your coverage** will be waived while **you** are receiving

benefits under the **policy**.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group long term disability 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.

[We will credit the period from the date **you** were continuously insured under the Prior Plan to the date **you** become insured under the **policy** towards satisfaction of the Pre-Existing Condition Limitation under the **policy**:

1. if **you** are no longer subject to the **policy's** Pre-Existing Condition Limitation, any benefit payable under the **policy** will be paid without applying the Pre-Existing Condition Limitation; and
2. if **you** are subject to the **policy's** Pre-Existing Condition Limitation, the Prior Plan's **pre-existing condition** exclusion will be applied. The benefits **we** pay **you** under the **policy** will then be the lesser of:
 - a. the amount, if any, that **you** would have received for that condition under the Prior Plan if it had remained in effect; or
 - b. the amount that **you** would have received under the **policy**, if **you** had no **pre-existing condition**.]

[In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our policy**; or
2. the Prior Plan, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our policy**, **we** will determine **your** payments according to **our policy's** provisions.

If **you** do not satisfy the **pre-existing condition** provision of this **policy**, but **you** do satisfy the Prior Plan's **pre-existing condition** provision:

1. **your** monthly payment will be the lesser of:
 - a. the monthly payment that would have been payable under the terms of the Prior Plan if it had remained in force; or
 - b. the monthly payment under **our policy**; and
2. benefits will end on the earlier of:
 - a. the date benefits end under **our policy**, as described under the Benefit Termination provision; or
 - b. the date benefits would have ended under the Prior Plan if it had remained in force.

If **you** do not satisfy either **our policy's** or the Prior Plan's **pre-existing**

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condition provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our policy** will apply.]

[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**.]]

Conditions for Payment of Long Term Disability Benefit

We will pay **you** a long term disability benefit if **you** become **partially** or **totally disabled**, while **you** are covered under the **policy**.

We will require proof, at **your** expense, that **you** are **disabled** in order to qualify for the benefit and at reasonable intervals thereafter. At **our** expense, **we** may also require that **you** be examined by **our** choice of **physicians** and/or vocational experts. **We** may also require **you** to be interviewed by an authorized company representative.

Benefit Payment

Your Monthly Benefit Amount will be paid monthly beginning one month after the **elimination period** ends for the prior one-month period. **You** will be paid a benefit for a **period of disability** up to the maximum monthly benefit, but no less than the minimum monthly benefit. Benefits will be paid until **you** are no longer **disabled** up to the Maximum Benefit Period shown in the Schedule of Benefits.

If **you** are **disabled** for less than a full month, **we** will pay **you** 1/30th of the Monthly Benefit Amount for each day of **partial disability** or **total disability**.

Benefit Termination

Benefits will stop on the earliest of the following dates:

- The date **you** are no longer **disabled** according to the **policy**;
- The date **you** reach the Maximum Benefit Period shown in the

- Schedule of Benefits;
- The date **you** die;
 - The date **you** fail to provide proof of continuing **disability**;
 - [The date **you** refuse to participate in an approved **rehabilitation program**];
 - The date **your disability earnings** exceed (80%) of **your indexed monthly earnings**. If **your disability earnings** fluctuate, **we** may average **your disability earnings** over a three (3) consecutive month period of time instead of stopping **your** payment on the date **your disability earnings** reach the earnings limit;
 - The date **you** cease to be under the **appropriate care** of a **physician**; or refuse to undergo, at **our** expense, an examination or testing by a **physician** or vocational, rehabilitation or health assessment testing when **we** require such examination or testing;
 - The date **you** refuse to receive medical treatment, including taking prescribed medicines, that **your physician** has recommended and that is generally acknowledged to cure or improve the **illness** or **injury** for which **you** are claiming benefits under the **policy** so as to reduce its disabling effect;
 - during the Regular Occupation Period when **you** are able to return to work in **your regular occupation** on a part-time basis but **you** do not;[or]
 - [after the Regular Occupation Period, when **you** are able to work in any **gainful occupation** on a part-time basis but **you** do not; or]
 - after 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

Determining Monthly Benefit Amount for a Total Disability

[To determine **your total disability** Monthly Benefit Amount:

1. multiply **your monthly earnings** by the benefit percentage shown in the Schedule of Benefits; and
2. take the lesser of:
 - a. the amount figured in step 1; or
 - b. the maximum monthly benefit shown in the Schedule of Benefits; and then
3. subtract the amount of Benefit Reductions.]

[To determine **your total disability** Monthly Benefit Amount:

Your monthly payment will be the monthly benefit amount **you** elected and for which premium is being paid, not to exceed [40%] of **your monthly earnings** or the maximum benefit, minus the Benefit Reductions.]

The monthly benefit will never be less than the minimum monthly benefit shown in the Schedule of Benefits.

Work Incentive Benefit

[During the first [12] months of benefit payments for **your partial disability, your** **Your** Monthly Benefit Amount for **your partial disability** will be based on the **total disability** Monthly Benefit Amount for a **total disability**, but will not be reduced by any **disability earnings you** receive until **your** Monthly Benefit amount plus **your disability earnings** exceed 100% of **your indexed monthly earnings**. If **your** Monthly Benefit Amount plus **your disability earnings** exceed 100% of **your indexed monthly earnings**, we will subtract the amount of earnings over 100% from **your** Monthly Benefit Amount. Any employment under this provision must be approved by **us** as reasonably leading to **your** return to **active work**.

If **we** do not approve a Work Incentive Benefit [or an approved Work Incentive Benefit exceeds the [12] month benefit payment period], **your partial disability** will be determined as described in the Determining Monthly Benefit Amount for a Partial Disability provision.

Determining Monthly Benefit Amount for a Partial Disability

To determine **your partial disability** Monthly Benefit Amount:

1. subtract any **disability earnings** from **your indexed monthly earnings**; and
2. divide the amount figured in step 1 by **your indexed monthly earnings**; and then
3. multiply the amount figured in step 2 by **your total disability** Monthly Benefit Amount as determined above.

The monthly benefit will never be less than the minimum monthly benefit shown in the Schedule of Benefits.

[Benefit Reductions

Your long term disability benefit will be reduced by income from any of the following sources that **you** receive or are eligible to receive as a result of **your [partial disability or] total disability** or retirement:

1. MISCELLANEOUS BENEFITS. Benefits for which **you** are eligible under:
 - a. any unemployment compensation law; or
 - b. [any occupational disease law]; or
 - c. any state compulsory benefit act or law; or
 - d. [any workers' compensation law; or]
 - e. any other law of similar intent.
2. MOTOR VEHICLE DISABILITY BENEFITS. Benefits for which **you** are eligible under the mandatory portion of any "no fault" motor vehicle plan, or any other law of similar intent.
3. SOCIAL SECURITY BENEFITS. Any benefits that **you** receive or are eligible to receive as disability payments or as retirement payments under the United States Social Security Act or any other country's equivalent of that act. **[We** will also reduce **your** benefit payment by any amount that **your** spouse or children receive or are eligible to receive under any of these acts, as payments

because of your disability or retirement.]

We will not reduce **your** payment by **your** Social Security Retirement income if **your** disability begins after **your** Social Security Normal Retirement date and **you** are already receiving Social Security Retirement payments.

4. **DISABILITY INCOME BENEFITS:** Any disability income benefits that **you** receive under any group insurance plan of the **covered employer** or any employer, any government retirement system related to **your** employment with the **covered employer**, any formal or informal salary continuation or sick leave program of the **covered employer**.

[5. [1099 INCOME:] Any amount **you** receive as income from any form of employment, including but not limited to renewal commissions and residual sales commissions.]

6. **OTHER INCOME.** Any amount **you** receive as income replacement from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

7. **RETIREMENT BENEFITS.** Retirement benefits from a plan sponsored by the **covered employer** or any state or federal government.

RETIREMENT BENEFITS: Reference to "retirement benefits" is limited to employer sponsored benefits that:

1. do not represent contributions that **you** made (payments that represent **your** contributions are deemed to be received over **your** expected remaining lifetime, regardless of when those payments are actually received); and
2. are payable upon:
 - a. early or normal retirement after **your** disability begins; or
 - b. disability, provided the payment does not reduce the amount of benefits that would have been paid by the plan at **your** normal retirement age.

ESTIMATING BENEFITS: **We** reserve the right to reduce **your** Monthly Benefit Amount by estimating Social Security benefits, state compulsory benefits and Workers' Compensation benefits. **We** will not reduce **your** Monthly Benefit Amount by these estimated benefits if **we** receive proof that **you** have applied for these benefits and **you** have signed an agreement to repay any overpayment and to allow **us** to obtain information on awards directly from the appropriate state or federal agency. When **we** receive proof of approval or final denial (meaning **you** have exhausted all appeals for these benefits), **we** will adjust **your** Monthly Benefit Amount and notify **you** of any refund to **us** required by **you** based on any overpayments.

In any case where **we** have reduced **your** Monthly Benefit Amount by estimated benefits, **we** will adjust **your** payment when **we** receive proof of the denial or of the actual amount **you** have received. **We** will make a

lump sum refund of any benefits due at that time.

LUMP SUM PAYMENTS: Benefit Reductions that are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum was paid or, if less, the **policy's** applicable Maximum Benefit Period. If no time period is stated, the sum will be prorated over **your** expected lifetime as determined by **us**, using appropriate actuarial tables.

COST OF LIVING FREEZE: **We** will not reduce **your** Monthly Benefit Amount by any increase in the amount of Benefit Reductions **you** receive from any source, except earnings from any form of employment, if the Benefit Reduction changes because of a cost of living increase that occurs automatically at any time after **you** satisfy the **elimination period**.

SOURCES OF INCOME THAT DO NOT REDUCE BENEFITS: **We** will not subtract from **your** gross disability benefit, income **you** receive from the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. non-qualified plans of deferred compensation;
7. pension plans for partners;
8. military pension and disability income plans;
9. credit disability insurance;
10. franchise disability income plans;
11. no fault automobile insurance plans, except where required by law;
12. individual disability plans paid by the employee;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).]

Survivor Benefit

We will pay a benefit to **your eligible survivor** if **we** receive proof that **your** death occurred:

1. while **you** were receiving or were eligible to receive payments for a **period of disability**; and
2. **your period of disability** had continued for 180 or more consecutive days.

This benefit will be a lump sum benefit equal to [3 times] **your last monthly benefit**.

We will first apply the Survivor Benefit to any overpayment which may exist on **your** claim.

If **you** have no **eligible survivors**, this benefit will be payable to **your** estate, unless there is none. In this case, no payment will be made.

[Advanced Survivor Benefit

You may receive **your** Survivor Benefit prior to **your** death if **you** have been diagnosed with a **terminal illness**.

We will pay **you** a lump sum amount equal to [3] months of **your last monthly benefit** if:

1. **your disability** had continued for [180] or more consecutive days; and
2. **you** have been diagnosed with a **terminal illness**; and
3. **you** are receiving or are eligible to receive monthly payments under the **policy**.

We will first apply the Advanced Survivor Benefit to recover any overpayment which may exist on **your** claim.

This benefit is available to **you** on a voluntary basis and will be payable one time only under the **policy**.

Your right to exercise this option and receive payment is subject to the following;

1. **you** must make this election in writing to **us**; and
2. **your physician** must certify in writing that **you** have a **terminal illness**.

If **you** receive this benefit prior to **your** death, no Survivor Benefit will be payable upon **your** death.]

[Child Care Expense Benefit

This provision applies during the first 30 months following the date **you** have satisfied the **elimination period**.

After the 4th week of **disability** following the **elimination period**, when **you** work or participate in a **rehabilitation program** approved by **us**, **you** will be reimbursed for Child Care Expenses for each Eligible Child.

“Child Care Expenses” mean the monthly expenses, up to [\$250] for each Eligible Child and not to exceed [\$1000] per month, charged by a licensed childcare provider. The childcare provider may not be a member of **your** immediate family or living in **your** residence. **You** must provide satisfactory proof to **us** that **you** incurred such charges.

This benefit will cease on the earlier of:

1. 30 months following the date **you** have satisfied the **elimination period**; or
2. the end of **your rehabilitation program**.

“Eligible Child” is **your** dependent child under age 13 who lives with **you** and is **your** child or **your** spouse’s child.

The term “child” includes natural, adopted, foster, or stepchild. An “adopted

child” is a child **you** have assumed legal obligation for total or partial support in anticipation of adoption regardless of whether a final adoption order is issued.]

[Cost of Living Adjustment Benefit

We will make a cost of living adjustment to **your** Monthly Benefit Amount after **you** have received [[6] months of monthly benefit payments][[one] full year[s] of monthly benefit payments]. In order to qualify for this benefit, **you** must be receiving benefits under the **policy** on the [next following anniversary of **your** first benefit payment]. Additional adjustments will be applied on [each subsequent anniversary] that **your partial disability** or **total disability** continues [up to [5] adjustments] in any one **period of disability**.

To determine **your** Monthly Benefit Amount after a cost of living adjustment:

1. multiply **your** current Monthly Benefit Amount by the lesser of;
 - a. [2%]; or
 - b. 2/3 of the percentage increase in the U.S. Bureau of Labor Consumer Price Index for Wage Earners and Clerical Workers (CPI_W) for the previous **calendar year**; and
2. add the amount figured in step 1 to **your** Monthly Benefit Amount. The resulting amount will not be subject to the maximum monthly benefit shown in the Schedule of Benefits. For the purpose of calculating these adjustments, **your** Monthly Benefit Amount will include any prior year’s cost of living adjustment.]

[Medical or COBRA Premium Disability Benefit

If **you** are **disabled** and receiving a monthly benefit for **disability** under the **policy**, **you** may be eligible to receive an additional Medical or COBRA Premium Disability Benefit.

This Medical or COBRA Premium Disability Benefit is subject to all other provisions of the **policy** other than as stated in this section.

Medical or COBRA Premium Disability Benefits are payable for **you** if **you** meet all of the following requirements:

1. **you** are insured under the **policy**;
2. **you** are **disabled** according to the terms of the **policy**;
3. **you** are receiving or are eligible to receive a monthly benefit for **disability** under the **policy**; and
4. **you** are paying premiums for medical coverage or COBRA Medical Coverage under **your covered employer’s** plan.

Benefits under this provision will begin the day after **you** satisfy all of the above requirements.

We will pay **you** an additional monthly benefit, equal to the lesser of:

1. the amount of the monthly premium **you** are paying for yourself only, for medical coverage or COBRA Medical Coverage, or
2. [\$500].

Your Medical or COBRA Premium Disability Benefit will not be reduced by any Benefit Reductions listed in the **policy**.

If **you** are eligible to receive a Medical or COBRA Premium Disability Benefit for less than 1 month, **we** will send **you** 1/30th of **your** payment for each day **you** are **disabled**.

The Medical or COBRA Premium Disability benefit will terminate the earliest of the following:

1. the date **you** are no longer receiving or are no longer eligible to receive a monthly benefit for **disability** under the **policy**;
2. the date **you** are no longer **disabled** under the terms of the **policy**;
3. the date **you** have received [18 -24]months of Medical or COBRA Premium Disability payments, for a combination of medical coverage and COBRA Medical Coverage;
4. the last day **you** are covered for medical coverage, or COBRA Medical Coverage;
5. the last day of the period for which **you** qualify for COBRA Medical Coverage; or
6. the date **you** failed to give **us** the required proof that **you** are paying premiums for medical coverage or COBRA Medical Coverage.

“COBRA” means the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 and any subsequent amendments.

“COBRA MEDICAL COVERAGE” means the continuation of Medical Coverage under the Employer’s plan as provided for under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

“MEDICAL COVERAGE” means coverage provided under the Employer’s health or medical plan that pays for **your** medical, hospital, or surgical expenses.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

If **you** suffer an **injury** that results in any of the losses shown below within 90 days of the date of the accident, **we** will pay **you** the Monthly Benefit Amount for the number of months shown below.

Payment of this benefit will not be subject to satisfying the **elimination period**. However, after the **elimination period** has been completed, this benefit will be paid in lieu of the regular monthly payment, not in addition to it. If **you** remain **disabled** beyond the number of monthly payments under this provision, benefits may continue as provided under the **policy**. The months **you** receive benefits under this provision will be excluded in computing the number of months **you** receive payments for **disability** and in computing any remaining **Maximum Benefit Period** for **disability**. If **you** die, this benefit will cease.

FOR LOSS OF:
PAYMENTS:

NUMBER OF MONTHLY

Voluntary Long Term Disability Insurance

Long Term Disability Benefit

Sight of Both Eyes	46
Both Hands	46
Both Feet	46
One Hand and One Foot	46
One Hand and Sight of One Eye	46
One Foot and Sight of One Eye	46
One Hand or One Foot	23
Sight of One Eye	23
Thumb and Index Finger of Either Hand	12

The maximum number of monthly payments for all losses suffered in any one accident shall be limited to that one loss for which the greatest number of monthly payments is provided in the above schedule.

Loss of hands and feet means loss by severance at or above the wrist or ankle joint. Loss of sight means legal blindness. Loss of thumb and index finger means actual severance at or above the knuckles joining each hand.]

[Pension Contribution Benefit

If **you** become **totally disabled** and **you** qualify for a long term disability benefit and have participated in the **covered employer's** pension plan for at least 3 months before **you** became **totally disabled**, then **you** may be eligible to receive an additional benefit.

This additional benefit will equal the amount **you** were contributing toward the pension plan as of the date of **your total disability**, but will not be more than [6%] of **your monthly earnings**.

We will pay this additional benefit to the Plan Administrator for deposit into the pension plan on **your** behalf.

We will stop paying this benefit on the earlier of:

1. the date **you** are no longer **totally disabled**; or
2. the date **you** return to any occupation; or
3. the date **you** stop participating in **your covered employer's** pension plan; or
4. the date **you** stop receiving **total disability** payments from **us** under the **policy**.]

[Progressive Income Benefit

We will pay **you** an additional benefit equal to [10%] of **your monthly earnings**, not to exceed [\$3,000] per month, if **you** are unable to perform the **material and substantial duties** of **your regular occupation** due to **your injury** or **illness**, and **you**:

1. are continuously not able to perform two or more **activities of daily living** without **stand-by help**; or
2. have a **cognitive impairment**; or
3. have a **terminal illness**.

Activities of daily living you are not able to perform, without **stand-by help**, prior to the effective date of **your coverage** will not be covered.

This additional benefit will terminate when **you** are able to continuously perform all of the **activities of daily living** without **stand-by help**. This does not include an **activity of daily living you** were not able to perform prior to **your** effective date of **coverage**.]

[Reasonable Accommodation Expense Benefit

If **you** return to work in any occupation for any employer, not including self-employment, as a result of a **reasonable accommodation** made by such employer, **we** will pay that employer a Reasonable Accommodation Expense Benefit up to the lesser of [\$1,000] or the equivalent of [2] months of **your** monthly benefit; but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the **reasonable accommodation** is approved by **us** in writing prior to its implementation. This benefit is available to **you** one time while **you** are insured under the **policy**.]

[Spouse and Elder Care Expense Benefit

This provision applies during the first 30 months following the date **you** have satisfied the **elimination period**.

After the 4th week of **disability** following the **elimination period**, when **you** work or participate in a **rehabilitation program** approved by **us**, **you** will be reimbursed for Eligible Spouse and Elder Care Expenses for each Eligible Family Member.

“Eligible Spouse and Elder Care Expenses” are the monthly expenses, up to [\$250] for each Eligible Family Member, and not to exceed a maximum of [\$1000] per month, **you** incur for the care of **your** Eligible Family Member that are:

1. charged by a licensed adult care provider; who is not a member of **your** immediate family or living in **your** residence; and
2. documented by receipts from the licensed adult care provider which includes the provider’s social security number or taxpayer identification number.

Eligible Spouse and Elder Care Expenses do not include expenses for which **you** are eligible for reimbursement under any other group plan or from any other source.

This benefit will cease on the earlier of:

1. 30 months following the date **you** have satisfied the **elimination period**; or
2. the end of **your rehabilitation program**.

“Eligible Family Member ” is:

1. **your** spouse;
2. **your** parents and grandparents; and
3. **your** spouse's parents and grandparents.

An Eligible Family Member must be:

1. incapable of caring for himself or herself as a result of a mental or physical impairment;
2. living with **you** as part of **your** household; and
3. chiefly dependent on **you** for support.

You must provide satisfactory proof to **us** that the Eligible Family Member is incapable of caring for himself or herself and is chiefly dependent on **you** for support.]

[401(k) Contribution Benefit

If **you** become **totally disabled** and **you** qualify for a long term disability benefit and have participated in the **covered employer's** 401(k) plan for at least 3 months before **you** became **totally disabled**, then **you** may be eligible to receive an additional benefit.

This additional benefit will equal the amount **you** were contributing toward the 401(k) plan as of the date of **your total disability**, but will not be more than [6%] of **your monthly earnings**.

We will pay this additional benefit to the Plan Administrator for deposit into the 401(k) plan on **your** behalf.

We will stop paying this benefit on the earlier of:

1. the date **you** are no longer **totally disabled**; or
2. the date **you** return to any occupation; or
3. the date **you** stop participating in **your covered employer's** 401(k) plan; or
4. the date **you** stop receiving **total disability** payments from **us** under the **policy**.]

[Mental Illness Limitation

Not more than [24] monthly benefit payments will be made [during **your** lifetime][per occurrence] for any **period of disability** due to **mental illness**, unless **you** are an inpatient at a **mental institution** or **hospital** at the end of that [24] months. In that event, monthly benefits will be paid while **your** confinement continues.

If **you** are still **disabled** when **you** are discharged, monthly benefits will continue during **your period of disability** for a recovery period of up to 90 days. During that 90-day recovery period, if **you** are again confined in a **mental institution** or **hospital** for a period of at least 14 consecutive days, benefits will continue during the **period of disability** while **you** remain confined and for another recovery period of 90 days.

In no event will monthly benefit payments for any one **period of disability** exceed the Maximum Benefit Period shown in the Schedule of Benefits.]

[Alcohol and Drug Abuse Limitation

Not more than [24] monthly benefit payments will be made [during **your** lifetime][per occurrence] for any **period of disability** due to alcohol and/or drug abuse, unless **you** are an inpatient at a **hospital, institution** or rehabilitation center at the end of that [24] months receiving **treatment** for the alcohol and/or drug abuse. In that event, monthly benefits will be paid while **your** confinement continues.

If **you** are still **disabled** when **you** are discharged, monthly benefits will continue during **your period of disability** for a recovery period of up to 90 days. During that 90-day recovery period, if **you** are again confined in a **hospital, institution** or rehabilitation center and receiving **treatment** for the alcohol and/or drug abuse for a period of at least 14 consecutive days, benefits will continue during the **period of disability** while **you** remain confined and for another recovery period of 90 days.

In no event will monthly benefit payments for any one **period of disability** exceed the Maximum Benefit Period shown in the Schedule of Benefits.]

[Special Conditions Limitation

We pay only a limited benefit for a **period of disability** due to Special Conditions. The Maximum Benefit Period [for all such **periods of disability**][per occurrence] is [24] months [during **your** lifetime]. [This is not a separate maximum for each such condition, or for each **period of disability**, but a combined maximum for all **periods of disability** and for all of these conditions.]

Your period of disability will be considered due to Special Conditions if:

1. **you** are limited by one or more of the stated conditions; and
2. **you** do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit **your** activities, and lead **us** to conclude that **you** were **disabled**.

Benefits may be payable for more than [24] months, but not beyond the Maximum Benefit Period in the Schedule of Benefits, if **you**:

1. are **hospital confined** at the end of the [24] month period above, and
2. remain **disabled**.

Benefits will be payable for the length of **your** confinement and for up to 90 days following the end of **your** confinement.

If **you** are **hospital confined** again during the 90-day period for at least 14 consecutive days, benefits will be payable for the length of the second confinement and for up to 90 days following the end of the second confinement.

Special Conditions means:

1. **Mental Illness**;
2. Musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, except:
 - a. arthritis;
 - b. herniated intervertebral discs;
 - c. scoliosis;
 - d. spinal fractures;
 - e. osteopathies;
 - f. spinal tumors, malignancy, or vascular malformations;
 - g. radiculopathies, documented by electromyogram;
 - h. spondylolisthesis, grade II or higher;
 - i. myelopathies and myelitis;
 - j. demyelinating disease;
 - k. traumatic spinal cord neurosis;
 - l. myofacial pain syndrome; or
 - m. shoulder sprains and strains;
3. Chronic fatigue syndrome;
4. Fibromyalgia;
5. Carpal Tunnel Syndrome;
6. Environmental allergic **illness**, including but not limited to sick building syndrome and multiple chemical sensitivity; or
7. Alcohol, drug or chemical abuse, dependency or addiction.]

Pre-Existing Condition Limitation

We will not pay **you** the Monthly Benefit Amount for a **partial disability** or **total disability** that is both:

1. caused by, attributed to, or that results, in whole or in part, from a **pre-existing condition**; and
 2. begins in the first [12 months] after the effective date of **your coverage** or any **new coverage** under the **policy** [unless **you** have been **treatment** free for [12] consecutive months after **your** effective date of **coverage**].
-

If **you** benefits under the **policy** are increased, **you** will not be paid the increased benefit amount (but **you** will receive the benefit in effect prior to the increase) for any **disability** caused by, attributed to, or that results, in whole or in part, from a **pre-existing condition** that begins in the first [12 months] after the increase became effective [unless **you** have been **treatment** free for [12] consecutive months after the increase became effective].

Exclusions

The **policy** will not cover any **period of disability** caused by, attributed to, or resulting from **your**:

1. elective procedure or surgery; or
2. engaging in any illegal or fraudulent occupation, work, or employment; or
3. traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes; or
4. participation in a war, or an act of war, declared or undeclared or any act of war; or
5. active military duty; or
6. active participation in a riot, rebellion or insurrection; or
7. attempting to commit, or committing, or participating in, an assault or felony; or
8. commission of a crime for which **you** have been convicted; or
9. intentionally self-inflicted **injury** or **illness**, while sane or insane; or
10. attempted suicide, while sane or insane[.]; or]
11. [being legally intoxicated[.]; or]
12. [being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **physician**][.]; or]
13. [occupational **illness** or **injury**, which is an **illness** or **injury** caused by or aggravated by any employment for pay or profit.]

We will not pay any benefits for any period that **you** are confined to any facility because **you** were convicted of a crime or other illegal act.

Voluntary Long Term Disability Insurance

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim 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 the **injury** or **illness** begins, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of an **injury** or **illness**.

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

Proof of Loss

You must send **us** a proof of loss within 90 days after the end of the **elimination period**.

We will not decline or reduce a claim if: (a) it is not reasonably possible to give proof within that time; and (b) the proof is submitted within one year from the date of loss or incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**. **Your** proof of loss must show:

1. that **you** are under the **appropriate care** of a **physician**; and
2. the date **your disability** began; and
3. the cause of **your disability**; and
4. the appropriate documentation of **your monthly earnings** and **your activities**; and
5. the extent of **your disability**, including restrictions and limitations preventing **you** from performing **your regular occupation**; and
6. the name and address of any **hospital** or **institution** where **you** received **treatment**, including all attending **physicians**; and
7. documentation of prior disability coverage if applicable.

We may request that **you** send proof of continuing **disability** indicating that **you** are under the continuous care and **treatment** of a **physician**. This proof, provided at **your** expense, must be received within 30 days of a request by **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**. All benefits to which **you** are entitled will be paid monthly during **your period of disability**. Any balance remaining unpaid at the end of that period will be paid as soon as possible after **we** receive the proof of loss.

Payment of Claims

All 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.

Claims for loss of life will be paid according to the Survivor Benefit provision in the Long Term Disability Benefit section.

Legal Actions

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

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were 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** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180] days after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [45] days after **we** receive **your** 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 **you** 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.

Recovery and Subrogation

When **your** injury or illness appears to be someone else's fault, any benefits otherwise due under the **policy** for a resulting **period of disability** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights

Voluntary Long Term Disability Insurance

Claims Provisions

of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

SERFF Tracking Number: SLIA-127087004 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48339
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.003 Long Term
 Product Name: Premier Choice - LTD
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/30/2011
Comments:		
Attachments:		
AR Certificate of Readability - LTD.pdf		
AR Certificate of Compliance - LTD.pdf		
AR Consumer Notice.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/30/2011
Comments:		
Approved 3/9/11 - SLIA-127053875		
Attachment:		
ERAPP.2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	03/30/2011
Comments:		
Attachment:		
LTD SOV Final.pdf		

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
GP2010TSB and GP2010TBP	41.5
GP2010VTSB and GP2010VTBP	43.6



Bryan Anderson, Executive VP - Operations

March 22, 2011

Date

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 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.

<hr/>	<hr/>	<hr/>
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.

<hr/>	<hr/>	<hr/>
Signature of Agent	Print Name of Agent	Date
Address:	Telephone #:	License #:
	Email:	

HOME OFFICE USE:

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Policy form number – GP2010TSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Effective date of current group coverage.
1	Plan Effective Date	Original effective date of group contract.
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 [15-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0-36]. Variable statements will be included if selected by policyholder.
1	Your Premium Contribution	Variable statement will be included if selected by policyholder.
1	Your Monthly Benefit Amount	<p>Variable statements will be included based upon policyholder's selection.</p> <p>Variable – [Core] only included if a core-buy-plan is selected by policyholder</p> <p><i>VARIABLE – Percentage range [30% - 75%]</i> <i>VARIABLE – Dollar range [\$1,000 - \$ 25,000]</i></p> <p><i>VARIABLE – Percentage range [40% - 80%]</i> <i>VARIABLE – Dollar range [\$2,000 - \$ 25,000]</i></p> <p><i>VARIABLE – Dollar range [\$1,000 - \$25,000]</i> <i>VARIABLE – Percentage range [30% - 75%]</i></p> <p><i>VARIABLE – Dollar range [\$2,000 - \$25,000]</i> <i>VARIABLE – Percentage range [40% - 80%]</i></p> <p><i>VARIABLE – Percentage range [5% - 30%]</i> <i>VARIABLE – Dollar range [\$50 - \$500]</i></p> <p><i>VARIABLE – Dollar range [\$0 - \$ 25,000]</i></p>
2	Residual Disability Benefit	Benefit will be included or not included based upon policyholder selection.
2	Elimination Period	Variable statements will be included based upon policyholder's selection. Day variable will range from [30-365].
2	Regular Occupation Period	Variable statements will be included based upon policyholder's selection. Month variable will range from [12-60].
2-5	Maximum Benefit Period	Variable statements will be included based upon policyholder's selection.
5	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	<p>Temporary Layoff] variable will be included if selected by policyholder.</p> <p>Injury or Illness month range [0-12]</p> <p>Leave of Absence month range [0-12]</p>
5	Advanced Survivor Benefit	Benefit will be included if selected by policyholder.
5	Child Care Expense Benefit	Benefit will be included if selected by policyholder.
5	Cost of Living Adjustment Benefit	Benefit will be included if selected by policyholder.

5	Medical or COBRA Premium Disability Benefit	Benefit will be included if selected by policyholder.
5	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Benefit will be included if selected by policyholder.
5	Pension Contribution Benefit	Benefit will be included if selected by policyholder.
5	Progressive Income Benefit	Benefit will be included if selected by policyholder.
5	Reasonable Accommodation Expense Benefit	Benefit will be included if selected by policyholder.
6	Spouse and Elder Care Expense Benefit	Benefit will be included if selected by policyholder.
6	401(k) Contribution Benefit	Benefit will be included if selected by policyholder.
6	Mental Illness Limitation	Limitation will be included if selected by policyholder.
6	Alcohol and Drug Abuse Limitation	Limitation will be included if selected by policyholder.
6	Special Conditions Limitation	Limitation will be included if selected by policyholder.

Policy form number – GP2010TBP

Defined Terms

Page #	Provision	Variables
1	Activities of Daily Living (ADL)	Definition will be included if Progressive Income Benefit is selected by policyholder.
1	Cognitive Impairment	Definition will be included if Progressive Income Benefit is selected by policyholder.
2	Elimination Period	Days variable will range from [7-30].
2	Gainful Occupation	Percentages will range from [70%-90%] – 80 Standard Percentages will range from [50%-80%] – 60 Standard
3	Maximum Capacity	Months variable will range from [12- 60].
4-5	Monthly Earnings	Variable statements will be included based upon policyholder’s selection. Month variable will range from [12-36].
6	Physician	[domestic partner] will be included if selected by policyholder
6	Pre-Existing Condition	Variable statement will be included if allowed by state law. Months variable will range from [3-24].
7	Reasonable Accommodation	Definition will be included if Reasonable Accommodation Expense Benefit is selected by policyholder.
7	Stand-by Help	Definition will be included if Progressive Income Benefit is selected by policyholder.
7	Terminal Illness	Definition will be included if Advanced Survivor Benefit is selected by policyholder. Months range variable will range from [3-24].
7	Total Disability, Totally Disabled	Percentage variable will range from [10%-40%]. First variable statement will be included standardly, Second variable statement will be included if Progressive Income Benefit selected. Month variable will range from [12-60].

10	Enrollment Requirement	Variable statement will be included if selected by policyholder.
10	Evidence of Insurability Requirement	#5 will be included for 2-9 lives product only
11	Termination of Your Long Term Disability Coverage	[Temporary Layoff] will be included if selected by policyholder
11	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence	Variable statement will be included if selected by policyholder.
12	Continuity of Coverage	Variable statements will be included based upon policyholder's selection.
14	Benefit Termination	Variable statements will only print if Mandatory Rehab.
15	Determining Monthly Benefit Amount for a Total Disability	Variable statement included will be based on policyholder selection. Percentage range [30% - 75]
15	Work Incentive Benefit	Month variable will range from [6-36]. Month variable will range from [6-36].
16-18	Benefit Reductions	Variable statements will be included or not included based upon policyholder's selection. Reference to partial disability will only be included if selected by policyholder.
18	Survivor Benefit	Multiplier variable will range from [1-24] times.
18	Advanced Survivor Benefit	Provision will be included if selected by policyholder. Months variable will range from [1-24]. Days variable will range from [30-365].
19	Child Care Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$50-\$ 5,000].
19 - 20	Cost of Living Adjustment Benefit	Provision will be included if selected by policyholder. Variable statements will be included or not included based upon policyholder's selection. Months variable will range from [3-10]; year[s] variable will range from [1-5]. Adjustments variable will range from [1-10]. Percentage variable will range from [1-10].
20 - 21	Medical or COBRA Premium Disability Benefit	Provision will be included if selected by policyholder. Dollar amounts – [\$200 - \$800] Month variable – [18 – 24]
21 - 22	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Provision will be included if selected by policyholder.
22	Pension Contribution Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [2%-20%].
22	Progressive Income Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [5-20]. Amount variable will range from [\$1,000-\$5,000].
23	Reasonable Accommodation Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$250-\$20,000]. Months variable will range from [1-6].
23 - 24	Spouse and Elder Care Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$50-\$ 5,000].
24	401(k) Contribution Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [2%-20%].

Limitations and Exclusions

25	Mental Illness Limitation	Provision will be included if selected by policyholder. Statement variable based on policyholder selection Month variable will range from [12-60].
25	Alcohol and Drug Abuse Limitation	Provision will be included if selected by policyholder. Statement variable based on policyholder selection Month variable will range from [12-60].
25 - 26	Special Conditions Limitation	Provision will be included if selected by policyholder. Statements variable based on policyholder selection Month variable will range from [12-60].
26 - 27	Pre-Existing Condition Limitation	Reference to treatment free will be included if selected by policyholder. <i>VARIABLE – Month range [3 – 24]</i> <i>VARIABLE – Month range [6 – 24]</i> <i>VARIABLE – Month range [3 – 24]</i> <i>VARIABLE – Month range [6 – 24]</i>
27	Exclusions	Variable statements will be included or not included based upon policyholder's selection.

Claim Provisions

29	Reconsideration of a Denied Claim	First day variable will range from [60-180] days. Second day variable will range from [60-180] days.
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Policy form number – GP2010VTSB

Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Effective date of current group coverage.
1	Plan Effective Date	Original effective date of group contract.
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 [15-40] hours
1	Waiting Period	Day variable will range from [0-365] or will be listed by month and range from [0- 36]. Variable statements will be included if selected by policyholder.
1	Your Premium Contribution	Variable statement will be included if selected by policyholder.
1	Your Monthly Benefit Amount	Variable statements will be included based upon policyholder's selection. 1. Percentages variable will range from [25%-80%]. 2. Amounts variable will range from [\$500-\$15,000]. Incremental Benefit: [\$500-\$1000] per month [\$100-\$500] increments [40%, 50%, 60%, 66 2/3%] of your monthly earnings [\$1000-\$10,000] maximum benefit Minimum monthly benefit variable will range from [5%-

		30%] and [\$50-\$500]. If evidence of insurability is required, Guarantee Maximum Benefit Amount variable will range from [\$0-\$15,000].
2	Residual Disability Benefit	Benefit will be included or not included based upon policyholder selection.
2	Elimination Period	Variable statements will be included based upon policyholder's selection. Day variable will range from [30-365].
2	Regular Occupation Period	Variable statements will be included based upon policyholder's selection. Month variable will range from [12-60].
2	Maximum Benefit Period	Variable statements will be included based upon policyholder's selection.
5	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	[Temporary Layoff] variable will be included if selected by policyholder. Injury or Illness month range [0-12] Leave of Absence month range [0-12]
5	Advanced Survivor Benefit	Benefit will be included if selected by policyholder.
5	Child Care Expense Benefit	Benefit will be included if selected by policyholder.
5	Cost of Living Adjustment Benefit	Benefit will be included if selected by policyholder.
5	Medical or COBRA Premium Disability Benefit	Benefit will be included if selected by policyholder.
5	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Benefit will be included if selected by policyholder.
5	Pension Contribution Benefit	Benefit will be included if selected by policyholder.
6	Progressive Income Benefit	Benefit will be included if selected by policyholder.
6	Reasonable Accommodation Expense Benefit	Benefit will be included if selected by policyholder.
6	Spouse and Elder Care Expense Benefit	Benefit will be included if selected by policyholder.
6	401(k) Contribution Benefit	Benefit will be included if selected by policyholder.
6	Mental Illness Limitation	Limitation will be included if selected by policyholder.
6	Alcohol and Drug Abuse Limitation	Limitation will be included if selected by policyholder.
6	Special Conditions Limitation	Limitation will be included if selected by policyholder.

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Defined Terms

Page #	Provision	Variables
1	Activities of Daily Living (ADL)	Definition will be included if Progressive Income Benefit is selected by policyholder.
1	Cognitive Impairment	Definition will be included if Progressive Income Benefit is selected by policyholder.
2	Elimination Period	Days variable will range from [7-30].
2	Gainful Occupation	Percentages will range from [50%-90%].
3	Maximum Capacity	Months variable will range from [12-60].
4	Monthly Earnings	Variable statements will be included based upon policyholder's selection. Month variable will range from [12-36].

6	Physician	[domestic partner] will be included if selected by policyholder
6	Pre-Existing Condition	Variable statement will be included if allowed by state law. Months variable will range from [3-24].
6	Reasonable Accommodation	Definition will be included if Reasonable Accommodation Expense Benefit is selected by policyholder.
7	Stand-by Help	Definition will be included if Progressive Income Benefit is selected by policyholder.
7	Terminal Illness	Definition will be included if Advanced Survivor Benefit is selected by policyholder. Months range variable will range from [3-24].
7	Total Disability, Totally Disabled	Percentage variable will range from [10%-40%]. First variable statement will be included standardly, Second variable statement will be included if Progressive Income Benefit selected. Month variable will range from [12-60].

Long Term Disability Benefit

9	Effective Date of your Long Term Disability Coverage	Variable statement will be included if selected by policyholder.
10	Enrollment Requirement	Variable statement will be included if selected by policyholder.
11	Termination of your Long Term Disability Coverage	[Temporary layoff] will be included if selected by policyholder.
11	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or Leave of Absence	[Temporary layoff] will be included if selected by policyholder.
12 - 13	Continuity of Coverage	Variable Provision and statements will be included based upon policyholder's selection.
13 - 14	Benefit Termination	Variable statements will only print if Mandatory Rehab.
14	Determining Monthly Benefit Amount for a Total Disability	Variable statement included will be based on policyholder selection. Percentage range [25-80%]
14 - 15	Work Incentive Benefit	Months variable will range from [6-36]. Month variable will range from [6-36].
15-17	Benefit Reductions	Variable statements will be included or not included based upon policyholder's selection. Reference to partial disability will only be included if selected by policyholder.
17	Survivor Benefit	Multiplier variable will range from [1-24] times.
17-18	Advanced Survivor Benefit	Provision will be included if selected by policyholder. Months variable will range from [1- 24]. Day variable will range from [30-365].
18	Child Care Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$50-\$ 5,000].
19	Cost of Living Adjustment Benefit	Provision will be included if selected by policyholder. Variable statements will be included or not included based upon policyholder's selection. Months variable will range from [3-10]; year[s] variable will range from [1-5]. Adjustments variable will range from [1-10]. Percentage variable will range from [1-10].
19 - 20	Medical or COBRA Premium	Provision will be included if selected by policyholder.

	Disability Benefit	Dollar amounts – [\$200 - \$800] Month variable – [18 – 24]
20 - 21	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Provision will be included if selected by policyholder.
21	Pension Contribution Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [2%-20%].
21 - 22	Progressive Income Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [5-20]. Amount variable will range from [\$1,000-\$5,000].
22	Reasonable Accommodation Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$250-\$20,000]. Month variable will range from [1-6].
22	Spouse and Elder Care Expense Benefit	Provision will be included if selected by policyholder. Amount variable will range from [\$50-\$ 5,000].
23	401(k) Contribution Benefit	Provision will be included if selected by policyholder. Percentage variable will range from [2%-20%].

Limitations and Exclusions

24	Mental Illness Limitation	Provision will be included if selected by policyholder. Statements variable based on policyholder selection. Month variable will range from [12-60].
24	Alcohol and Drug Abuse Limitation	Provision will be included if selected by policyholder. Statements variable based on policyholder selection. Month variable will range from [12-60].
24 - 25	Special Conditions Limitation	Provision will be included if selected by policyholder. Statements variable based on policyholder selection. Month variable will range from [12-60].
25 - 26	Pre-Existing Condition Limitation	Reference to treatment free will be included if selected by policyholder. Month variable will range from [3-24].
26	Exclusions	Variable statements will be included or not included based upon policyholder's selection.

Claim Provisions

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