

SERFF Tracking Number: UNUM-127084886 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 49338
 Company Tracking Number: GROUP TERM LIFE 1.0
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: GTL1.0
 Project Name/Number: Group Term Life 1.0/Group Term Life 1.0

Filing at a Glance

Company: Colonial Life & Accident Insurance Company

Product Name: GTL1.0

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TOI: L04G Group Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 49338

Sub-TOI: L04G.500 Other

Co Tr Num: GROUP TERM LIFE State Status: Approved-Closed
1.0

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Cathy Brooks, Angela
Parker, Lauren Sease, Annette
Smith, Tyra Marshall, Jessica
Reece

Disposition Date: 07/20/2011

Date Submitted: 07/18/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Term Life 1.0

Status of Filing in Domicile: Pending

Project Number: Group Term Life 1.0

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, Association

Overall Rate Impact:

Filing Status Changed: 07/20/2011

State Status Changed: 07/20/2011

Deemer Date:

Created By: Jessica Reece

Submitted By: Annette Smith

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your consideration and approval are the following new group term life forms. The forms include an Accelerated Death Benefit and optional Accidental Death & Dismemberment and Waiver of Premium benefits. These optional benefits are only available in conjunction with Group Term Life Insurance.

Form Number Description Flesch Score

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GTL1.0-P-AR Group Term Life Policy 51.3
GTL1.0-C-AR Group Term Life Certificate 50.7
GTL-B-S - Master Policyholder Application (Basic and Supplemental)
GTL-V - Master Policyholder Application (Voluntary)
GTL-Enroll Group Enrollment Form
GTL-E of I Evidence of Insurability Form
GTL-Port Portability Application
GTL1.0-P-Amend Policy Amendment
GTL1.0-C-Amend Certificate Amendment

The forms do not replace any forms currently on file with your department. The readability scores for these forms are listed above. The text of the forms is uniform and no less than ten (10) point font size.

The Conversion Policy (CWL) and the Conversion Application (GTL-Conversion) used to convert coverage will be submitted through a separate SERFF filing.

The Group Term Life product will be marketed in employer/employee and association or union groups by licensed Colonial Life & Accident Insurance Company agents and through relationships with insurance brokers. The issue ages for this product will range from 0-99.

We certify, prior to issuance of coverage to an association, we will submit the Affidavit, By-laws and Articles of Incorporation to your department for review.

Premiums may be paid 100% by the employees or by full or partial contributions from the policyholder.

Sample benefit amounts are included within the brackets. Statements of Variability are included with this filing and provide complete information on benefit amounts, and more detailed information regarding the plan variability.

Enrollment methods include agent-assisted situations, in person or via call centers, and self-enrolled situations, using paper or electronic enrollment processes, such as web-based. In some situations where the premium is fully policyholder paid, enrollment may be by employee/member listing provided by the policyholder. Electronic enrollment processes may also be used in agent-assisted situations.

The policyholder application, group enrollment form, evidence of insurability form and portability application are also enclosed for your review and approval. These forms include brackets. An underwriting Statement of Variability is included with this filing and provides more detailed information about the brackets.

The Accelerated Death Benefit Disclosure form and amendment forms are also enclosed for your review and approval.

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The amendment forms will be used to add new benefits or to document changes made in accordance with policy provisions.

Actuarial memorandums are included in this submission. Also included is the filing fee of \$450.00.

The forms are scheduled to be submitted to our domicile state, South Carolina.

Company and Contact

Filing Contact Information

Jessica Reece, Contract Consultant jeblack@coloniallife.com
 1200 Colonial Life Boulevard 800-845-7330 [Phone] 86286 [Ext]
 Columbia, SC 29202

Filing Company Information

Colonial Life & Accident Insurance Company	CoCode: 62049	State of Domicile: South Carolina
1200 Colonial Life Boulevard	Group Code: 565	Company Type:
Post Office Box 1365	Group Name:	State ID Number:
Columbia, SC 29202	FEIN Number: 57-0144607	
(803) 798-7000 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$450.00
Retaliatory?	No
Fee Explanation:	\$50.00 x 9 (forms) = \$450.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Life & Accident Insurance Company	\$450.00	07/18/2011	49878652

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/20/2011	07/20/2011

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Disposition

Disposition Date: 07/20/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Accelerated Death Benefit Disclosure Form	Yes	Yes
Supporting Document	Statements of Variability	Yes	Yes
Supporting Document	Annual Earnings Definitions	Yes	Yes
Supporting Document	Actuarial Memorandums	No	No
Form	Group Term Life Policy	Yes	Yes
Form	Group Term Life Certificate	Yes	Yes
Form	Policyholder Application (Voluntary)	Yes	Yes
Form	Group Enrollment Form	Yes	Yes
Form	Evidence of Insurability Form	Yes	Yes
Form	Portability Application	Yes	Yes
Form	Policy Amendment	Yes	Yes
Form	Certificate Amendment	Yes	Yes
Form	Policyholder Application (Basic and Supplemental)	Yes	Yes

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Form Schedule

Lead Form Number: GTL1.0-P

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GTL1.0-P-AR	Policy/Cont	Group Term Life ract/Fratern al Certificate	Initial		51.300	GTL1.0-P-AR.pdf
	GTL1.0-C-AR	Certificate	Group Term Life Certificate	Initial		50.700	GTL1.0-C-AR.pdf
	GTL - V - Master	Application/	Policyholder Enrollment Form (Voluntary)	Initial			GTL Master App Vol reg 75217 John Doe.pdf
	GTL - Enroll	Application/	Group Enrollment Enrollment Form	Initial			GTL Enroll - reg 74914 John Doe.pdf
	GTL - E of I	Application/	Evidence of Enrollment Form Insurability Form	Initial			GTL E of I - 74916 reg John Doe.pdf
	GTL - Port	Application/	Portability Enrollment Form	Initial			GTL Portability Form - Reg 74915 John Doe.pdf
	GTL1.0-P- Amend	Policy/Cont	Policy Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			Policy Amendment - reg John Doe.pdf
	GTL1.0-C-	Certificate	Certificate	Initial			Certificate

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Amend GTL - B - S - Master	Amendmen t, Insert Page, Endorseme nt or Rider Application/Policyholder Enrollment Application (Basic Form and Supplemental)	Initial	amendment - reg John Doe.pdf GTL Master App B-S reg 74913 John Doe.pdf
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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202

1.800.325.4368 coloniallife.com]

A Stock Company

GROUP TERM LIFE INSURANCE POLICY NON-PARTICIPATING – DOES NOT PAY DIVIDENDS

THIS POLICY CONTAINS AN ACCELERATED DEATH BENEFIT

The life insurance benefit as specified under this policy will be reduced upon payment of an accelerated death benefit. The benefit paid under the accelerated death benefit provision may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

Please Read This Policy Carefully

This policy is a legal contract between the policyholder and us. To understand the coverage, this policy must be read as a whole.

Throughout this policy the word **you** or **your** means a named insured who is insured under this coverage. **Covered person(s)** includes the named insured, plus any covered spouse and dependent children, if applicable. **We, us, our** or **Colonial Life** means Colonial Life & Accident Insurance Company. **Named insured** refers to the person who is the member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Policyholder** means the organization named on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** is the group contract held by the policyholder and available for review by the named insured. The male pronoun includes the female whenever used.

This policy is issued in consideration of the application of the policyholder, a copy of which is attached to and made a part of this policy, and the payment of premium when due. This policy takes effect at 12:01 a.m. Standard Time at the policyholder's address on the Policy Effective Date shown on the Policy Rate Schedule.

We agree to pay, in accordance with the terms of this policy, the benefit amounts of the policy. Details of the benefits are shown in the certificate.

The policyholder should read this policy carefully and contact us promptly with any questions. [This policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.]

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
501.371.2640
1.800.852.5494

SECTION II – POLICY GUIDE

SECTION I – FACE PAGE

SECTION II – POLICY GUIDE

SECTION III – POLICY RATE SCHEDULE

SECTION IV – POLICYHOLDER PROVISIONS

SECTION V – PREMIUM PAYMENTS

SECTION VI – TERMINATION

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION III – POLICY RATE SCHEDULE

Policyholder: [ABC Employer]

Policy Number: [987654321]

Policyholder Address: [123 Any Street]

Billing Control Number: [E123456]

Policy Effective Date: [01/01/2011]

Governing Jurisdiction: [Any State]

Policy Anniversary: [01/01/2012]

Eligible Class(es)

[All employees in active employment working at least [20] hours per week.]

[Active Employment] means you are working for the policyholder at the worksite for earnings that are paid regularly, and you are performing the material and substantial duties of your regular occupation. You will not be considered in active employment if employment status is being continued under a severance or termination agreement. The worksite must be:

- the policyholder's usual place of business;
- an alternative worksite at the direction of the policyholder; or
- a location to which your job requires you to travel.]

[Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.]

[Material and substantial duties] means duties that are normally required for the performance of your regular occupation, and cannot be reasonably omitted or modified.]

[Regular occupation] means the occupation you routinely perform on your job.]

Waiting period:

For individuals in an eligible class on policy effective date: [365]

For individuals entering an eligible class after policy effective date: [365] days after entering into an eligible class unless waived as described in the Certificate of Coverage.

[Rehire:

If your employment with the policyholder ends and you become employed by the policyholder again within one year, your previous work in an eligible class will apply toward the waiting period. All other policy provisions apply.]

Eligibility period: [31] days

Policyholder Plan Choice for Life [and Accidental Death & Dismemberment (AD&D)] Benefit Amount For You:

[A member of an eligible class receives:

[\$50,000]

[Multiple of annual earnings: [2.0 times annual earnings up to a maximum benefit amount of [\$1,000,000]]]]

[A member of an eligible class chooses from the following options:

[\$1,000 increments from a minimum benefit amount of \$10,000 up to a maximum benefit amount of [\$1,000,000]

[Multiple of annual earnings: [2.0] times annual earnings, [2.5] times annual earnings, [3.0] times annual earnings, [3.5] times annual earnings, [4.0] times annual earnings] from a minimum benefit amount of \$10,000 up to a maximum benefit amount of [\$1,000,000]]

[Policyholder Plan Choice for Accidental Death & Dismemberment (AD&D) Benefit Suites:

[Travel Suite – Common Carrier [with Motor Vehicle] Benefit, Disappearance Benefit, Repatriation Benefit]

[Family Suite – Child Care Benefit, Career Adjustment for Spouse Benefit, Education for Dependent Children Benefit]]

[Maximum Face Amount of Life [and Accidental Death & Dismemberment (AD&D)] Insurance Benefit

[For your spouse

The lesser of:

- [100]% of your face amount; or
- [\$500,000]]

[For your children

Attained age at death:

- Live birth to 6 months of age: \$1,000

Greater than 6 months of age to age 26:

The lesser of:

- [100]% of your face amount; or
- [\$20,000]]]

Accelerated Death Benefit Maximum

The lesser of:

75% of the life coverage face amount or [\$500,000] for any covered person

This policy may include enrollment, risk management and other support services related to the policyholder's benefit program.

Cost for Life Insurance Benefit

[Composite Rate [\$x.xxx] per \$1,000 per individual]

[Life Insurance Initial Premium Rate Tables

Named insured

Monthly premium rate per \$1,000 of life insurance face amount per named insured

The named insured's attained age	Nontobacco Use	Tobacco Use
0-24	\$x.xxx	\$x.xxx
25-29	x.xxx	x.xxx
30-34	x.xxx	x.xxx
35-39	x.xxx	x.xxx
40-44	x.xxx	x.xxx
45-49	x.xxx	x.xxx
50-54	x.xxx	x.xxx
55-59	x.xxx	x.xxx
60-64	x.xxx	x.xxx
65-69	x.xxx	x.xxx
70-74	x.xxx	x.xxx
75+	x.xxx	x.xxx]

[Spouse

Monthly premium rate per \$1,000 of life insurance face amount per spouse

The spouse's attained age	
0-24	\$x.xxx
25-29	x.xxx
30-34	x.xxx
35-39	x.xxx
40-44	x.xxx
45-49	x.xxx
50-54	x.xxx
55-59	x.xxx
60-64	x.xxx
65-69	x.xxx
70-74	x.xxx
75+	x.xxx]

[**Dependent Children:** monthly rate of [\$x.xxx] per \$1,000 of life insurance face amount

The total face amount of life insurance for which a dependent child is insured under this policy is subject to the maximum benefit available at certain ages.]]

[Cost for Accidental Death & Dismemberment (AD&D) Insurance Benefit

Base Accidental Death & Dismemberment (AD&D) Insurance Benefit Initial Premium Rate Tables

Named insured: Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount

[**Spouse:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]

[**Children:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]

Base Accidental Death & Dismemberment (AD&D) Insurance Benefit Plus [Travel Suite] Initial Premium Rate Tables

Named insured: Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount

[**Spouse:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]

[**Children:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]]

Base Accidental Death & Dismemberment (AD&D) Insurance Benefit Plus [Family Suite] Initial Premium Rate Tables

Named insured: Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount

[**Spouse:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]

[**Children:** Monthly Premium Rate of: [\$x.xxx] per \$1,000 of AD&D full amount]]

[The total AD&D amount for which a child is insured under this policy is subject to the maximum benefit available at certain ages.]]

Rate Guarantee Period: A change in the premium rate table(s) will not take effect before [three years] after the policy effective date.

[Divisions, subsidiaries or affiliated companies include:

Name/location (city and state)]

SECTION IV – POLICYHOLDER PROVISIONS

Ownership

The policyholder is the owner of this policy and may agree with us to change it without the consent of or notice to the covered persons or their assignees.

Entire Contract

This entire contract consists of:

- all policy provisions and any amendments or endorsements issued;
- the policyholder's master application attached to this policy;
- each named insured's enrollment form or evidence of insurability form, if applicable; and
- the certificates issued under this policy.

Changes to the Contract

This policy may be changed in whole or in part.

Amendments and endorsements add provisions to or change the terms of the policy. Any changes made to this policy, other than a change in the premium we charge, must be in writing and evidenced by endorsement on this policy, or by amendment to this policy signed by the policyholder and one of our executive officers at our home office. No agent, broker or anyone else can change this policy or waive any of its provisions.

Furnishing Certificates

We will provide a certificate for each named insured. The certificate will provide a description of the insurance provided by this policy and will state:

- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

Contestability

After two years from the Policy Effective Date, no misstatements made by the policyholder in the application, except for fraudulent misstatements, will be used to void this policy or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

Conformity with State Statutes

Any provision of this policy that is in conflict with the applicable state laws of the state in which the named insured resides when he becomes insured is amended to conform to the minimum requirements of those laws.

New Entrants

Any member of an eligible class, as described in the Policy Rate Schedule, and the eligible dependents of those members will become insured when they satisfy the requirements set forth in the "Enrollment and Coverage Effective Dates" provision of the named insured's certificate of coverage.

Information to be Furnished by the Policyholder

The policyholder must keep a record of the named insureds and the particulars of the insurance on each and on the covered spouse and dependent children, if applicable. As changes occur, the policyholder should provide us, on forms acceptable to us, information relative to any persons:

- who are eligible to enroll;
- who are insured by the coverage;
- occupational information and any other information that may be required to manage a claim;
- whose status changes; and/or
- whose coverage terminates pursuant to the "Termination of Insurance" provision.

The policyholder should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time. We may inspect these records at any time while this policy is in force and within one year after the termination of this policy.

All statements made in any application are considered representations and not warranties (absolute guarantees). No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the master application.

Clerical error or omission by us will not:

- prevent a covered person from receiving coverage;
- affect the amount of a covered person's coverage; or
- cause a covered person's coverage to begin or continue when the coverage would not otherwise be effective.

Electronic Transactions

Any transaction relating to this policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law. Any notice required by the provisions of this policy given by written, electronic and telephonic, as applicable, means will have the same force and effect as notice given in writing.

SECTION V – PREMIUM PAYMENTS

Premium Payments

The initial premium for each type of coverage under this policy is based on the initial premium rate table(s) shown on the Policy Rate Schedule.

Premium Amount

To ensure accurate premium calculations, the policyholder is responsible for reporting to us the following information during the stated time periods:

- individuals who are eligible to enroll are to be reported during the month prior to or during the month the coverage becomes effective;
- covered persons whose coverage has terminated are to be reported within a month of the date coverage terminated; and
- changes in named insureds' class are to be reported within a month of the date that the change in insurance class took place.

When and Where to Pay Premium

The premiums for each certificate must be remitted to us at our home office when they are due.

If premiums are not paid when they are due or within the grace period, the coverage provided by this policy will terminate at the end of the grace period. The premium due dates are based on:

- the Policy Effective Date shown on the Policy Rate Schedule; and
- the premium frequency.

Premium frequency is how often premiums are paid. The premium must be paid in U.S. dollars.

The policyholder is liable for premium for coverage during the grace period. The policyholder must pay all premium due for the full period each certificate is in force.

Increases or Decreases in Premium

We have the right to change the premium we charge after notifying the policyholder in writing at least [45] days in advance. A change in premium rate table(s) will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule except for reasons which affect the risk assumed, including, but not limited to those reasons shown below:

- a change occurs in this policy;
- a division, subsidiary, or affiliated company is added or deleted;
- the number of insureds changes by 25% or more; or

- a new law or a change in any existing law is enacted which applies to this policy.

After the rate guarantee period, we can change the premium rate table(s) at any time. A change may take effect on an earlier date when both we and the policyholder agree in writing.

Premium increases or decreases which take effect during an insurance month are due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next [31] days. These [31] days are called the **grace period**. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

SECTION VI – TERMINATION

Termination

This policy can be cancelled:

- by us; or
- by the policyholder.

If we cancel this policy for reasons other than the policyholder's failure to pay premium, a written notice will be delivered to the policyholder at least 60 days prior to the cancellation date.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be cancelled on an earlier date. If we or the policyholder cancels this policy, coverage will end at 12:00 midnight at the policyholder's address on the last day of coverage.

If this policy is cancelled, the cancellation will not affect a claim for which we are liable under the terms of this policy.

Policyholder Responsibility to Named Insureds

If this policy terminates for any reason, the policyholder must:

- notify each named insured of the effective date of the termination; and
- refund or otherwise account to each named insured all contributions received or withheld from them for premiums not actually paid to us.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

**GROUP TERM LIFE INSURANCE
CERTIFICATE OF COVERAGE
NON-PARTICIPATING – DOES NOT PAY DIVIDENDS**

THIS CERTIFICATE CONTAINS AN ACCELERATED DEATH BENEFIT

The life insurance benefit as specified under this certificate will be reduced upon payment of an accelerated death benefit. The benefit paid under the accelerated death benefit provision may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

Please Read This Certificate Carefully

This is your certificate of coverage. You will want to read it carefully and keep it in a safe place.

Throughout this certificate the word **you** or **your** means the named insured who is insured under this coverage. **Covered person(s)** includes the named insured, plus any covered spouse and dependent children, if applicable. **We, us, our** or **Colonial Life** means Colonial Life & Accident Insurance Company. **Named insured** refers to the person who is the member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Policyholder** means the organization named on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** is the group contract held by the policyholder and available for review by you. The male pronoun includes the female whenever used.

If the terms and provisions of this certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. The policy and this certificate may be changed in whole or in part. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, broker or anyone else may change the policy or waive any part of it.

[The policy is delivered in and is governed by the laws of the governing jurisdiction (and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments). When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.]

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
501.371.2640
1.800.852.5494**

SECTION II – CERTIFICATE GUIDE

SECTION I – FACE PAGE

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SECTION III – CERTIFICATE SCHEDULE

SECTION IV – YOUR CERTIFICATE WITH US

SECTION V – ENROLLMENT AND COVERAGE EFFECTIVE DATES

SECTION VI – TERMINATION OF INSURANCE

SECTION VII – OTHER IMPORTANT PROVISIONS

SECTION VIII – LIFE INSURANCE BENEFIT

SECTION IX – ACCELERATED DEATH BENEFIT

SECTION X – LOSSES NOT COVERED

[SECTION XI – ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT]

[SECTION [XII] – WAIVER OF PREMIUM]

[SECTION [XIII] – PORTABILITY]

SECTION [XIV] – CONVERSION PRIVILEGE FOR LIFE INSURANCE

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION III – CERTIFICATE SCHEDULE

Named Insured: [Joe Smith] Certificate Number: [0000000000]
Issue Age: [00] Governing Jurisdiction: [Any State]
Coverage Effective Date: [MM/DD/YYYY] Monthly Premium at Issue Age:* [\$XX.XX]
Policyholder: [ABC Employer] Group Policy Number: [9876543210]
Policy Effective Date: [01/01/2011] Billing Control Number: [E123456]

*Subsequent premiums based on attained age on each policy anniversary. [For a multiple of salary plan, premiums are also subject to change based on any change in salary.]

LIFE COVERAGE:

	Face Amount
You:	[\$50,000]
[Your Spouse:	[\$25,000]]
[Your Dependent Children:	
Live birth to six months of age	\$1,000
Greater than six months of age to age 26	[\$10,000]]

This contract reduces benefits for a covered person at ages 70 and 75. See the Benefit Reduction Due To Age Schedule in "Life Insurance Benefit" provision of this certificate. The above coverage amounts reflect benefit reductions based on the covered person's issue age.

[For spouse and dependent child coverage, see the "If Your Spouse or Dependent Child Is Disabled" provision in the Enrollment and Coverage Effective Dates provision of this Certificate.]

[Maximum Guaranteed Issue Amount:	
[For You:	[\$50,000]]
[For Your Spouse:	[\$25,000]]
[For Your Dependent Children:	[\$10,000]]]

[Evidence of insurability is not required for amounts you had in force with the policyholder's prior carrier on the termination date of the prior carrier's plan.]

Some losses may not be covered. See "Losses Not Covered" in this certificate.

[ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFIT:

	Full Amount
You:	[\$50,000]
[Your Spouse:	[\$25,000]]
[Your Dependent Children:	
Live Birth to six months of age	\$1,000
Greater than six months of age to age 26	[\$10,000]]

This contract reduces benefits for a covered person at ages 70 and 75. See the benefit reduction due to age schedule in the “Accidental Death & Dismemberment Insurance Benefit” provision of this certificate. The above coverage amounts reflect benefit reductions based on the covered person’s issue age.

[For spouse and dependent child coverage, see the “If Your Spouse or Dependent Child Is Disabled” provision in the Enrollment and Coverage Effective Dates provision of this Certificate.]

Accidental Death Insurance Benefit for You [and Your Spouse] [and Your Dependent Children]:

Benefit paid as shown in the Accidental Death Insurance Benefit within the Certificate.

Accidental Dismemberment Insurance Benefit for You [and Your Spouse] [and Your Dependent Children]:

Benefit paid as shown in the Accidental Dismemberment Insurance Benefit within the Certificate.

Seatbelt and Airbag Benefit for You [and Your Spouse] [and Your Dependent Children]:

Benefit paid as shown in the Seatbelt and Airbag Benefit within the Certificate.]

[Paralysis Benefit for You:

Benefit paid as shown in the Paralysis Benefit within the Certificate.]

[Coma Benefit for You:

Benefit paid as shown in the Coma Benefit within the Certificate.]

[Burn Benefit for You:

Benefit paid as shown in the Burn Benefit within the Certificate.]

[Common Carrier [with Motor Vehicle] Benefit for You:

Benefit paid as shown in the Common Carrier [with Motor Vehicle] Benefit within the Certificate.]

[Disappearance Benefit for You:

See the “Disappearance Benefit” provision within the Certificate.]

[Repatriation Benefit for You:

Benefit paid as shown in the Repatriation Benefit within the Certificate.]

[Child Care Benefit for You:

Benefit paid as shown in the Child Care Benefit within the Certificate.]

[Career Adjustment for Spouse Benefit for You:

Benefit paid as shown in the Career Adjustment for Spouse Benefit within the Certificate.]

[Education for Dependent Children Benefit for You:

Benefit paid as shown in the Education for Dependent Children Benefit within the Certificate.]

[Line of Duty Benefit for You:

Benefit paid as shown in the Line of Duty Benefit within the Certificate.]

[Felonious Assault Benefit for You:

Benefit paid as shown in the Felonious Assault Benefit within the Certificate.]

[Human Immunodeficiency Virus (HIV) Benefit for You:

Benefit paid as shown in the Human Immunodeficiency Virus (HIV) Benefit within the Certificate.]

[Hepatitis B or C Benefit for You:

Benefit paid as shown in the Hepatitis B or C Benefit within the Certificate.]

Some losses may not be covered. See “Losses Not Covered Under the AD&D Insurance Benefit” in this certificate.]

[Waiver of Premium:

Waiver of Premium Elimination Period: [270 days]

Waiver of Premium Duration: [to age 65]]

[Premium payments **are required** for you while you are disabled under this certificate.]

Definition of Annual Earnings

[Annual earnings means your gross annual income from your employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation from this employer, or income received from sources other than your employer.]

WHO PAYS FOR THIS COVERAGE:

For you:

[You pay 100% of the cost of your coverage.]

[The Policyholder pays the cost of your coverage.]

[You and the Policyholder share the cost of your coverage.]

[For your [spouse] [and] [dependent children]:

[You pay 100% of the cost of the coverage.]

[The Policyholder pays the cost of the coverage.]

[You and the Policyholder share the cost of the coverage.]]

SECTION IV – YOUR CERTIFICATE WITH US

Certificate

Certificate means a document that provides a description of the coverage provided by the policy and states:

- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

SECTION V – ENROLLMENT AND COVERAGE EFFECTIVE DATES

Enrollment

An individual who is a member of an eligible class may enroll in coverage provided under the policy during the eligibility period, as shown on the Policy Rate Schedule that follows the latest of:

- the policy effective date as shown on the Policy Rate Schedule;
- the date he first becomes a member of an eligible class;
- the date he completes the waiting period shown on the Policy Rate Schedule; or
- the date he meets evidence of insurability requirements, if any.

An individual who fails to enroll during the eligibility period may enroll only during an enrollment period. The policyholder and we will determine when an enrollment period begins and ends.

Waiting Period

If you have been continuously [employed by the policyholder] for a period of time equal to your waiting period, we will waive your waiting period when you enter an eligible class.

We will apply any prior period of [employment with the policyholder] toward the waiting period to determine your eligibility date.

Amount of Coverage

The amount of coverage is shown on the Certificate Schedule. Evidence of insurability is required for any amount of life insurance over the maximum guaranteed issue amount, if any, shown on the Certificate Schedule.

Evidence of Insurability means a statement of medical history which we will use to determine if an applicant is approved for coverage. Blood profiles and medical examinations, if applicable, will be provided at our expense.

[Continuation of Coverage

In order to prevent loss of coverage for a member of an eligible class under the prior carrier's plan when this policy replaces a group life policy the policyholder had in force with us or another insurer immediately prior to the effective date of this policy, we will provide the following coverage.

- For a member of an eligible class, evidence of insurability will not be required for amounts in force with the policyholder's prior carrier on the termination date of the prior carrier's plan. The amounts in force may not exceed the maximum face amount of life [and AD&D] insurance shown on the Policy Rate Schedule. Also, the amounts of insurance are subject to the provisions of the prior carrier's plan, and any and all exclusions, reductions, limitations, and/or specific termination dates or provisions of that plan will apply.
- An individual who was not actively at work on the termination date of the prior carrier's plan may become insured under this policy as of the effective date, subject to all of the following conditions:
 - he was insured under the prior carrier's plan immediately prior to termination of the plan;
 - premiums for the individual are paid up to date under the prior carrier's plan; and
 - he is not receiving or eligible to receive benefits under the prior carrier's plan.

[We will also provide coverage for your spouse or dependent child if:

- your spouse or dependent child is totally disabled; and

- your spouse or dependent child was covered by the prior carrier's plan on its termination date.]

Premium payments are required for you [and your spouse and dependent children] during the period this coverage continues in force. We will not waive premiums during the period continuation of coverage continues.

The amounts of insurance will be the lesser of:

- the benefit payable under this policy; or
- the benefit payable under the prior carrier's plan had it remained in force.

Coverage provided under this "Continuation of Coverage" provision will automatically end on the earliest of the date you return to active employment, the date you [or your spouse or dependent child] recover[s] and no longer [are] [is] disabled or the date this policy is cancelled.

The "Portability" provision under this policy will not apply.

All other provisions of our policy will apply.]

Coverage Effective Date

Your coverage under the policy will start at 12:01 a.m. Standard Time in the time zone where you live on the coverage effective date shown on your Certificate Schedule.

Delayed Coverage Effective Date

The effective date of your coverage will be delayed for you if you are not a member of an eligible class on the coverage effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this certificate covers your spouse and/or your dependent children, coverage on your spouse or dependent children will be effective on the date that you return to status as a member of an eligible class. However, see the "If Your Spouse or Dependent Child Is Disabled" provision for requirements applying to your spouse or dependent child who is totally disabled.

When You Can Change Your Coverage

You can change coverage for you or your covered spouse or dependent children, if applicable, by applying for additional benefits only during an enrollment period or following certain family status changes. You must be in active employment in order to change your coverage. A family status change that qualifies for an increase in coverage includes marriage, birth, adoption or placement for adoption. You can increase coverage up to the maximum benefit available under the policy. [You may not increase coverage for your spouse and dependent children.] Evidence of insurability may be required for any increase in coverage after the initial eligibility period under the policy.

In addition, you can decrease your coverage during an enrollment period or following certain family status changes. You must be in active employment in order to change your coverage. A family status change that qualifies for a decrease in coverage includes divorce, legal separation, annulment or death of a spouse or dependent. Any decrease in coverage will not affect a payable claim that occurs prior to the decrease.

Payable Claim means a claim for which we are liable under the terms of the policy.

When Changes to Your Coverage Take Effect

A change in coverage that is made during an enrollment period will begin at 12:01 a.m. Standard Time in the time zone where you live on the next premium due date after an enrollment period. A change in coverage that is made following a family status change will begin at 12:01 a.m. Standard Time in the time zone where you live on the next premium due date after the request for the change is made.

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by the policyholder will take effect at 12:01 a.m. Standard Time in the time zone where you live on the next premium due date after the change is made. You must be in active employment. [If a claim is paid during the policy year based on the new coverage amount, and additional premium is due because of a salary change, this additional premium will be deducted from any claim payment.]

If you are not in active employment due to injury or sickness or a temporary layoff or leave of absence, any increased, additional or decreased coverage due to a change in your annual earnings or due to a plan change will begin on the next premium due date after the date you return to active employment. Any decrease in coverage will not affect a payable claim that occurs prior to the decrease.

Temporary layoff or leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

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

[When You Are Eligible for Dependent Coverage]

If you elect coverage for yourself or are insured under the policy, you are eligible to elect coverage for your spouse only, your dependent children only or both.

The date your spouse or dependent children are eligible for coverage is the later of:

- the date your coverage begins; or
- the date you first acquire a spouse or dependent child.

Spouse includes your lawful spouse, including a legally separated spouse. You may not cover your spouse if your spouse is enrolled for coverage as a named insured.

After your coverage begins, you may apply for spouse or dependent children coverage within 31 days of a family status change.

In order to be considered a dependent child, the child must be your or your spouse's natural child; stepchild; adopted child, including a child placed with you or your spouse for the purpose of adoption; or any other child related to you or your spouse by blood or marriage (unless either of the child's parents also resides with you or your spouse). On the day we issue coverage, the child must be:

- living with you or your spouse in a regular parent-child relationship;
- under age 26; and
- unmarried.

After we issue dependent child coverage, a new parent-child relationship is established:

- by the birth of a living child;
- by the legal adoption, including a child placed with you for the purpose of adoption, of a child under age 26; and
- when you marry and acquire a stepchild who is less than 26 years of age.

We consider a dependent child to be age 26 on the policy anniversary on or after his 26th birthday.

No dependent child may be covered by more than one named insured under the policy. No dependent child may be covered as both a named insured and a dependent child.]

[If Your Spouse or Dependent Child is Disabled]

If your eligible spouse or dependent child is totally disabled, your spouse or dependent child's coverage will begin on the earlier of:

- the first premium due date after he is no longer totally disabled; or
- two years after the date that coverage would have otherwise become effective for the spouse or dependent child.

This provision does not apply to a newborn child who is born while dependent child coverage is in effect.

For purposes of this provision, **Totally Disabled** means that, as a result of an injury or a sickness, your spouse or dependent child:

- is confined in a hospital or similar institution;
- is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;
- is unable to attend school outside of the home, provided your dependent child is of school age (ages 5-26 years of age); or

- is at a developmental age which is less than half his chronological age by milestones or other pediatric developmental testing (e.g., Denver Developmental Test or similar test) provided your dependent child is of pre-school age (up to six years of age).

Activities of Daily Living means:

- **Bathing** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Eating** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring** means the ability to move in or out of a chair, bed or wheelchair.

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

SECTION VI – TERMINATION OF INSURANCE

When Your Coverage Ends

Your coverage under the Policy ends on the earliest of:

- the date the policy is terminated;
- the date you are no longer in an eligible class;
- [the date your class is no longer included for insurance;]
- the end of the grace period following the premium due date we fail to receive the required premium for you; or
- the last day you are in active employment [unless continued due to a temporary layoff or leave of absence or due to an injury or sickness, as described in "If You Stop Working After Your Coverage Begins" provision]; or
- the date the next premium is due after you ask us to end your coverage.

We will provide coverage for a payable claim which occurs while you are covered under the policy.

[When Spouse or Dependent Child Coverage Ends

Your spouse's coverage will end on the earliest of:

- the date your coverage terminates;
- the date of legal divorce or annulment; or
- the date you ask us to end your spouse's coverage.

Coverage for any one dependent child will end on the earliest of:

- the date your coverage under the policy terminates;
- the date your dependent child ceases to be an eligible dependent child; or
- the date you ask us to end your dependent children's coverage.

We will provide coverage for a payable claim which occurs while your spouse or dependent children are covered under the policy.

If Your Dependent Child Becomes Disabled While Covered Under the Policy

Coverage will continue for a dependent child age 26 or over who became physically or mentally disabled while covered under the policy, provided:

- the child is unmarried;
- the disability was acquired before the child's coverage would be terminated;
- the child is incapable of self-support and remains so incapable;
- you are the main source of support and maintenance.

We must receive proof within 31 days of the date the dependent child attains age 26 and as required during the first two years thereafter. After the first two years, we will ask for proof when needed, but not more than once a year.

Coverage for the disabled dependent child will end when your coverage ends.]

[If You Stop Working After Your Coverage Begins

Once your coverage begins, if you are not working due to injury or sickness and if premium is paid, you may continue to be covered up to your retirement date.

If you are on a temporary layoff or leave of absence, and if premium is paid, you will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. **Sickness** means an illness or disease.]

[Family and Medical Leave Act

If you are on a Family and Medical Leave of Absence, we will continue your coverage in accordance with the employer's human resource policy on family and medical leaves of absence if premium payments continue and the employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to the employee for an injury or sickness, up to your retirement date.

If the employer's human resource policy does not provide for continuation of coverage for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.]

SECTION VII – OTHER IMPORTANT PROVISIONS

Proof of Loss

If claim is based on death or other covered loss, proof of loss for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss;
- the name and address of any hospital or institution where treatment was received, including all attending physicians; and
- any other documentation required by provisions of this certificate in order to receive a benefit.

In some cases, you or your representative will be required to give us authorization to obtain additional medical and non-medical information as part of your proof of loss. We can deny your claim if the appropriate information is not submitted.

When to Notify Us of a Claim

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

Written, electronic or telephonic notice and proof of loss must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than one year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of loss.

You or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from us within 15 days of the request, send us written, electronic or telephonic proof of loss without waiting for the form.

Claim Overpayment

We have the right to recover any overpayments due to:

- fraud; and
- any error we make in processing a claim.

We must be reimbursed in full. We will determine the method by which the repayment is to be made.

We will not recover more money than the amount we paid you.

Physical Examinations and Autopsy

We can require that any covered person be examined by a physician of our choice at our expense while his claim is pending. In case of death, we will have the right and opportunity to request an autopsy at our expense where not forbidden by law.

Legal Action

We cannot be sued for benefits under the policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

Statements in Application

We consider any statements you or the policyholder make in a signed application for coverage or an evidence of insurability form, if applicable, a representation and not a warranty. If any of the statements you or the policyholder make are not complete and true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the Coverage Effective Date.

We cannot take this action after your coverage has been in effect during the lifetime of the covered person for two years from the Coverage Effective Date.

If the policyholder gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under this certificate and in what amounts; and
- make a fair adjustment of the premium.

Misstatement of Age

If there is an error in any covered person's age, we will adjust the benefits to the amount of benefits which the total premiums paid would have bought at the correct issue age.

Misstatement of Tobacco Status

If there is a misstatement in the application of the named insured's tobacco status, we will adjust the benefits payable to the amounts which would have been purchased at the correct tobacco status in consideration of the most recent premium. We will not make such an adjustment after this policy has been in force for two years from the coverage effective date.

Insurance Fraud

We want to ensure that you and the policyholder do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We will support fraud detection, investigation and prosecution. We will pursue all appropriate legal remedies in the event of insurance fraud.

The Policyholder

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of Colonial Life.

How to Designate or Change a Beneficiary

At the time you become insured, you should name a beneficiary for your death benefits on your enrollment form. You may change your beneficiary at any time by filing a form approved by us at our home office. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before we receive that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you or are disqualified, we may pay at our option a part of the death benefit not exceeding \$10,000 to any person appearing to us to be equitably entitled to it because he incurred funeral or other expenses from your last illness or death. Any remaining portion of your death benefit will be paid to the first surviving family members in the order listed below:

- spouse or, if applicable, your domestic partner who is covered under this certificate as a spouse;
- children;
- parents;
- sisters and brothers; or
- to your estate.

If you do not survive your spouse, and spouse or dependent child life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

Your Right to Assign this Policy

You may assign (transfer) all or some of your rights under this certificate by sending us a properly completed assignment form. If we receive the form properly completed, the change will go into effect the day you sign the request. The change will not affect any payments made or action we took before we received the change. Both your rights and those of your beneficiary are subject to the terms of the assignment. We are not responsible for the validity or sufficiency of any assignment or the tax effects thereof.

Workers' Compensation Not Affected

The policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

SECTION VIII – LIFE INSURANCE BENEFIT

Our Obligation - Life Insurance

Upon receiving proof satisfactory to us that the covered person died while this certificate was in force, we will pay the death benefit of this certificate, subject to the provisions of this certificate. The beneficiary designated by the named insured will receive payment of the death benefit when we approve the death claim on the named insured. All benefits payable upon the death of any covered spouse or dependent child will be paid to you, if living, otherwise to the beneficiary of the spouse or dependent child life coverage if one was named by your surviving spouse after your death; otherwise to the estate of the covered spouse or dependent child.

The death benefit is the amount payable under the life insurance coverage when a covered person dies and is equal to the life coverage face amount shown on the Certificate Schedule, minus any due and unpaid premium and any amount advanced to you in an earlier payment.

How We Pay the Proceeds

While the covered person is living, you have the right to choose how we will pay the death benefit. If you do not make a choice before the covered person dies, the beneficiary may choose how the death benefit is to be paid.

We will pay the death benefit in a lump sum or in any other way on which we and you, or the beneficiary, if applicable, agree. If you or the beneficiary chooses to leave the death benefit on deposit with us, we will pay interest at a rate not less than that required by law in the governing jurisdiction.

Benefit Reduction Due to Age Schedule

If a covered person has reached age 70 but not 75, the life coverage face amount for the covered person will be:

- 65% of the life coverage face amount prior to age 70; or
- 65% of the life coverage face amount applied for if the covered person becomes insured on or after age 70 but before age 75.

If a covered person has reached age 75 or more, the life coverage face amount for the covered person will be:

- 50% of the life coverage face amount prior to the first reduction; or
- 50% of the life coverage face amount applied for if the covered person becomes insured on or after age 75.

Once reduction begins, there will be no further increases in the covered person's life coverage face amount.

Earnings If Disabled or On Leave

If you die while you are disabled or on a covered temporary layoff or leave of absence, and your death benefit is based on your annual earnings, we will use your annual earnings from your employer in effect just prior to the date your absence began to determine your benefit.

Questions Concerning Your Claim

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

SECTION IX – ACCELERATED DEATH BENEFIT

Accelerated Death Benefit

The accelerated death benefit is a benefit which allows you to be advanced a portion of the death benefit if any covered person is diagnosed with a terminal illness after the coverage effective date. **Terminal illness** means an injury or sickness which results in any covered person having a life expectancy of 12 months or less and from which there is no reasonable prospect for recovery.

Accelerated Death Benefit Amount

You may request an amount of up to 75% of the life coverage face amount payable for the covered person who has the terminal illness up to a maximum shown on the Policy Rate Schedule. The minimum accelerated death benefit payment is \$5,000. This certificate must be in force on the date of payment and must have a life coverage face amount of at least \$10,000.

The accelerated death benefit amount payable to you is reduced:

- first by any due and unpaid premium; then
- by the administrative fee charged by us for accelerated death benefit payments, in the amount in effect at the time of payment, not to exceed \$200; then
- the remaining sum is discounted for a time period of one year using an interest rate no greater than the greater of: (a) the current yield on 90 day treasury bills; or (b) the current maximum statutory adjustable policy loan interest rate.

The remaining life coverage face amount will be paid according to the terms of the policy subject to any benefit reduction due to age schedule and termination provisions.

We will pay this benefit to you during the covered person's lifetime while the certificate is in force, upon receipt of all of the following:

- a completed accelerated death benefit request form; and
- proof that the covered person has been diagnosed with a terminal illness. Such proof will include a statement from the covered person's licensed physician, and any other medical information we deem necessary to confirm the health status; and
- written consent of any irrevocable beneficiary or any assignee, if applicable, agreeing that you may elect the death benefit advance.

Payment of this benefit will be made only once per covered person.

A **Physician** means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by his license.

For purposes of this definition, physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

We reserve the right to require confirmation of the terminal illness with a second opinion by an additional examination by a licensed and qualified physician of our choice. Any second opinion shall be done at our expense and shall be conclusive as to whether any covered person suffers from a terminal illness.

Premium payments must continue to be paid on the full life coverage face amount unless you qualify to have your premium waived.

How We Pay this Benefit

We will pay the accelerated death benefit in a lump sum. Upon payment of the accelerated death benefit, the life coverage face amount of the certificate for the covered person will be reduced by the amount of accelerated death benefit requested by you.

Taxability of Benefits

The amount paid under this benefit may be taxable. We are not responsible for any tax on or other effects of any benefit paid. As with all tax matters, consult your personal tax advisor to assess the impact of this benefit.

SECTION X – LOSSES NOT COVERED

Losses Not Covered under Your Life Insurance Benefit

Your life insurance benefit does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after a covered person's initial effective date of insurance, whether sane or insane; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective, whether sane or insane.

[SECTION [XI] – ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFIT

How We Pay the Proceeds

Unless otherwise specified below, the beneficiary designated by the named insured will receive payment of all benefits payable upon the accidental death of the named insured when we approve the claim. All benefits payable upon the accidental death of any covered spouse or dependent child will be paid to you, if living, otherwise to the beneficiary of the spouse or dependent child life coverage if one was named by your surviving spouse after your death; otherwise to the estate of the covered spouse or dependent child.

All benefits payable upon any other loss covered by the AD&D insurance benefit will be payable to you, if living, otherwise to the first surviving family members in the order listed below:

- spouse or, if applicable, your domestic partner who is covered under this certificate as a spouse;
- children;
- parents;
- sisters and brothers; or
- to your estate.

Benefit Reduction Due to Age Schedule

If a covered person has reached age 70 but not 75, the AD&D full amount for the covered person will be:

- 65% of the AD&D full amount prior to age 70; or
- 65% of the AD&D full amount applied for if the covered person becomes insured on or after age 70 but before age 75.

If a covered person has reached age 75 or more, the AD&D full amount for the covered person will be:

- 50% of the AD&D full amount prior to the first reduction; or
- 50% of AD&D full amount applied for if the covered person becomes insured on or after age 75.

Once reduction begins, there will be no further increases in the covered person's AD&D full amount.

Accidental Death Insurance Benefit

Upon receiving proof satisfactory to us that the covered person died due to an accident while this certificate was in force, we will pay the accidental death benefit of this certificate, subject to the provisions of this certificate. The death must occur within 365 days of the accident. The accident must occur while the covered person is covered under the certificate.

The accidental death benefit is the amount payable under the AD&D insurance benefit when a covered person dies and is equal to the AD&D full amount shown on the Certificate Schedule for that covered person, minus any due and unpaid premium and any amount paid to you in an earlier payment due to a loss suffered by that covered person.

Accidental Dismemberment Insurance Benefit

Upon receiving proof satisfactory to us that a covered person incurred one of the covered losses listed below as the result of accidental bodily injury, we will pay a benefit. The benefit will be a portion of the AD&D full amount for that covered person shown on the Certificate Schedule corresponding to the covered loss. The portion of the AD&D full amount that we will pay is listed below. The accidental bodily injury must result in one or more of the covered losses listed below within 365 days of the date of the accident. **Accidental bodily injury** means a bodily injury that is the direct result of an accident and not related to any other cause. We will presume you suffered an accidental bodily injury if you are unavoidably exposed to the elements and as a result of the exposure suffer a loss covered under the AD&D insurance benefit. The accident must occur while the covered person is covered under the certificate for AD&D insurance benefit.

Covered Losses	Benefit Amounts
Loss or loss of use of both hands or both feet or sight of both eyes	100% of the full amount
Loss or loss of use of one hand and one foot	100% of the full amount
Loss or loss of use of one hand and sight of one eye	100% of the full amount
Loss or loss of use of one foot and sight of one eye	100% of the full amount
Loss of speech and hearing	100% of the full amount
Loss or loss of use of one hand or one foot	50% of the full amount
Loss of sight of one eye	50% of the full amount
Loss of speech or hearing	50% of the full amount
Loss of thumb and index finger of same hand	25% of the full amount

For purposes of this benefit, the following definitions apply. **Loss of a hand** means that the hand is cut off through or above the wrist joint. **Loss of use of a hand** means the loss of function of the entire hand from the wrist to the fingertips. **Loss of a foot** means that the foot is cut off through or above the ankle joint. **Loss of use of a foot** means the loss of function of the entire foot from the ankle to the toes. **Loss of sight of one eye** means at least 80% of vision is permanently lost in the eye, such that it cannot be corrected to any functional degree by any procedure, aid or device. **Loss of hearing** means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. **Loss of speech** means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device. **Loss of thumb and index finger** means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

Benefits payable under this benefit reduce the AD&D full amount for that covered person payable for death as the result of the same accident.

The most we will pay for any combination of covered losses from any one accident is the AD&D full amount.

Seatbelts and Airbags Benefit

Upon receiving proof satisfactory to us that a covered person sustains an accidental bodily injury which causes the covered person's death while driving or riding in a private passenger vehicle, we will pay an additional benefit provided one or both of the following circumstances applies:

For Seatbelts:

We will pay 10% of the AD&D full amount shown on the Certificate Schedule up to a maximum benefit of \$25,000 provided:

- the private passenger vehicle is equipped with seatbelts;
- the seatbelts were in actual use by the covered person and properly fastened at the time of the covered accident; and

- the position of the seatbelts is certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that a covered person was properly wearing a seatbelt, then we will pay the seatbelts benefit.

However, if such certification is not available, and it is unclear whether the covered person was properly wearing a seatbelt, then we will pay a fixed benefit of \$1,000.

For Airbags:

We will pay 5% of the AD&D full amount shown on the Certificate Schedule up to a maximum benefit of \$5,000 provided:

- the private passenger vehicle is equipped with an airbag for the seat in which the covered person is seated;
- the seatbelts were in actual use by the covered person and properly fastened at the time of the covered accident; and
- the position of the seatbelts is certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that a covered person was properly wearing a seatbelt, then we will pay the airbag benefit.

NOTICE: Colonial Life & Accident Insurance Company does not advocate the placement of small children in the front seat of a motor vehicle. Consult your state department of motor vehicles for current safety standards.

No benefit will be paid if a covered person is the driver of the private passenger vehicle and does not hold a current and valid driver's license.

No benefit will be paid if we are able to verify that the airbag had been disengaged prior to the accident.

The accident causing death must occur while the covered person is covered under the certificate for AD&D insurance benefit. To receive the Seatbelts and Airbags Benefit, the accidental death benefit on the covered person must be paid first.

[Paralysis Benefit

Upon receiving proof satisfactory to us that you sustain an accidental bodily injury which results in your being paralyzed, as defined below, we will pay a benefit. The benefit will be a portion of the AD&D full amount shown on the Certificate Schedule. The portion of the AD&D full amount we will pay is listed below. The paralysis must occur within 365 days of the accidental bodily injury. The accident must occur while you are covered under the certificate for AD&D insurance benefit. A charge must be incurred for treatment of the accidental bodily injury.

Covered Losses	Benefit Amounts
Quadriplegia	100% of the AD&D full amount
Triplegia	75% of the AD&D full amount
Paraplegia	75% of the AD&D full amount
Hemiplegia	50% of the AD&D full amount
Uniplegia	25% of the AD&D full amount

Quadriplegia means total and irreversible paralysis of all four limbs.

Triplegia means total and irreversible paralysis of three limbs.

Paraplegia means total and irreversible paralysis of both lower limbs.

Hemiplegia means total and irreversible paralysis of both limbs on either side of the body (i.e. the right arm and right leg or the left arm and left leg).

Uniplegia means total and irreversible paralysis of one limb.

Benefits payable under this benefit reduce the full amount for the accidental death benefit payable for death as the result of the same accident.]

[Coma Benefit

Upon receiving proof satisfactory to us that you sustain an accidental bodily injury which results in your being in a coma, as defined below, and you remain in a coma for more than 31 days, we will pay a monthly benefit for each month that you remain in a coma after the first 31 days. The monthly benefit will be 1% of the AD&D full amount shown on the Certificate

Schedule. We will pay the monthly benefit for a maximum of 100 months. The accident must occur while you are covered under the certificate for AD&D insurance benefit. A charge must be incurred for treatment of the accidental bodily injury.

For purposes of this benefit, **Coma** means a continuous state of profound unconsciousness characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The term “Coma” does not include any medically induced coma.

Benefits payable under this benefit reduce the full amount for the accidental death benefit payable for death as the result of the same accident.]

[Burn Benefit

Upon receiving proof satisfactory to us that you are disfigured due to a 3rd degree burn (full thickness) as the result of accidental bodily injury, we will pay a benefit. The accident must occur while you are covered under the certificate for AD&D insurance benefit. The benefit will be a portion of the AD&D full amount shown on the Certificate Schedule. The portion of the full amount that we will pay is determined by the amount of the body surface actually suffering a 3rd degree burn as described below. The attending physician will determine the measurement of the amount of the body surface actually suffering a 3rd degree burn. A charge must be incurred for treatment of the accidental bodily injury.

The most we will pay for any combination of covered losses from any one accident is the AD&D full amount.

Burn Schedule

Covered Losses	Benefit Amounts
At least 9 square inches but less than 18 square inches	5% of the AD&D full amount
At least 18 square inches but less than 35 square inches	10% of the AD&D full amount
35 or more square inches	30% of the AD&D full amount

Benefits payable under this benefit reduce the full amount for the accidental death benefit payable for death as the result of the same accident.]

[Common Carrier [with Motor Vehicle] Benefit

Upon receiving proof satisfactory to us that you sustain an accidental bodily injury which causes your death under the following circumstances, we will pay an additional benefit:

- [while you are driving or riding in a private passenger car;
- when you are struck by a motor vehicle; or]
- while you are riding as a passenger in a public conveyance.

Public Conveyance means any land or water conveyance licensed for the transportation of passengers for hire or any aircraft operated by a business organized to operate an aircraft service and licensed for the transportation of passengers for hire. The accident must occur while you are covered under this certificate for AD&D insurance benefit.

The amount payable is equal to the AD&D full amount shown on the Certificate Schedule.

To receive the Common Carrier [with Motor Vehicle] Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Disappearance Benefit

For purposes of the Accidental Death Insurance Benefit, we will presume you suffered loss of life due to an accident if:

- you are riding in a public conveyance that is involved in an accident covered under this certificate;
- as a result of the accident, the public conveyance is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 365 days of the accident.

Public Conveyance means any land or water conveyance licensed for the transportation of passengers for hire or any aircraft operated by a business organized to operate an aircraft service and licensed for the transportation of passengers for hire. The accident must occur while you are covered under this certificate for AD&D insurance benefit.

The accident must occur while you are insured under this certificate.]

[Repatriation Benefit

Upon receiving proof satisfactory to us that you died due to an accident while this certificate was in force and your death occurred at least 75 miles away from your principal place of residence, we will pay an additional benefit for the preparation and transportation of your body to a mortuary. The death must occur within 365 days of the accident. The accident must occur while you are covered under the certificate.

We will pay the amount charged up to a maximum payment of \$5,000.

To receive the Repatriation Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Child Care Benefit

Upon receiving proof satisfactory to us that you died due to accidental bodily injury while this certificate was in force, we will pay an additional benefit for child care for each of your qualified children. The death must occur within 365 days of the accident. The accident must occur while you are covered under the certificate. Proof must be furnished to us that the child is a qualified child. We will pay your spouse, if applicable, or your authorized representative.

Qualified child for the purposes of this section means your natural child, stepchild, legally adopted child, foster child or a child placed into your custody for adoption who is less than age 14.

The annual benefit for each of your qualified children will be equal to the lesser of 5% of the AD&D full amount or \$3,000. The annual benefit will be paid for no more than a maximum benefit period of four consecutive years. However, the Child Care Benefit will terminate for each qualified child on the earliest of the following dates:

- the date your spouse or your authorized representative fails to furnish proof as required by us;
- the date your child no longer meets the definition of a qualified child; or
- the end of the maximum benefit period.

If, at the time of your death, you have no qualified child eligible for the child care benefit, we will pay 5% of the AD&D full amount to a maximum benefit of \$2,000 to your beneficiary.

To receive the Child Care Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Career Adjustment for Spouse Benefit

Upon receiving proof satisfactory to us that you died due to accidental bodily injury while this certificate was in force, and your spouse enrolls in a professional or trade school training program for the purpose of obtaining an independent source of support and maintenance, we will pay an additional benefit for Career Adjustment for Spouse. The death must occur within 365 days of the accident. The accident must occur while you are covered under the certificate. The enrollment must occur within 365 days of your death. We will pay your spouse.

The amount paid will be a lump sum equal to the lesser of 5% of the AD&D full amount or \$5,000.

To receive the Career Adjustment for Spouse Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Education for Dependent Children Benefit

Upon receiving proof satisfactory to us that you died due to accidental bodily injury while this certificate was in force and your qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level, we will pay an additional benefit for education for each of your qualified children. The death must occur within 365 days of the accident. The accident must occur while you are covered under the certificate. We will pay your spouse, if applicable, or your authorized representative.

Qualified child for the purposes of this section means any one of your dependent children who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or

- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

The annual benefit for each of your qualified children will be equal to the lesser of 6% of the AD&D full amount or \$6,000. The annual benefit will be paid for no more than four years. Provided, however, that no benefit payment will be made more than six years from the date the first benefit payment was made.

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer meets the definition of a qualified child;
- the end of the maximum benefit period; or
- the maximum number of annual benefit payments has been made.

To receive the Education for Dependent Children Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Line of Duty Benefit

Upon receiving proof satisfactory to us that you died due to an accident while this certificate was in force and the accident occurred while you were employed as a public safety officer and on duty for your employer, we will pay an additional benefit for Line of Duty, subject to the provisions of this certificate. The accident must occur while you are covered under the certificate.

The amount paid will be a lump sum equal to the lesser of [50%] of the AD&D full amount or [\$50,000].

A **Public Safety Officer** means a person whose primary job duties include controlling or reducing crime, criminal law enforcement and fire suppression.

To receive the Line of Duty Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Felonious Assault Benefit

Upon receiving proof satisfactory to us that you died due to an accident that consisted of a felonious act of violence while this certificate was in force, we will pay an additional benefit for Felonious Assault, subject to the provisions of this certificate. The felonious act of violence must occur while you are covered under the certificate.

The amount paid will be a lump sum equal to the lesser of 20% of the AD&D full amount or \$20,000.

A felonious act of violence means an act that is considered a felony where the act occurred. The felonious act of violence must occur while you are working for your employer, at your employer's usual place of business, at an alternative worksite at the direction of the employer, including your home, or a location to which your job requires you to travel. The benefit is not payable if the loss occurred while you were committing a felonious act.

To receive the Felonious Assault Benefit, your Accidental Death Insurance Benefit must be paid first.]

[Human Immunodeficiency Virus (HIV) Benefit

Upon receiving proof satisfactory to us that you sustain an accidental bodily injury in the performance of your occupation duties causing you to acquire and test positive for HIV within 365 days of the date of the accident, we will pay a monthly benefit. The portion of the AD&D full amount we will pay is listed below. The accident must occur while you are covered under the certificate for AD&D insurance benefit. A charge must be incurred for treatment of the accidental bodily injury.

The monthly benefit will be 0.8333% of the AD&D full amount. We will pay the monthly benefit for a maximum of 24 months.

In order to receive the HIV Benefit, you must:

- submit a Workers' Compensation injury report or similar proof to your employer within 72 hours of the accident; and
- submit to us a blood test for Human Immunodeficiency Virus antibody performed within 72 hours of the accident.

If the initial blood test is negative and you subsequently test positive for HIV within 365 days of the accident, we will begin monthly payments.

[If you test positive for HIV and Hepatitis B or C as a result of the same occupational accident, only one benefit amount will be paid.]

The HIV benefit will terminate on the earlier of the following dates:

- the date you die; or
- the date the last of the maximum number of installments is paid.

Benefits payable under this benefit reduce the full amount for the Accidental Death Insurance Benefit payable for death as the result of the same accident.]

[Hepatitis B or C Benefit

Upon receiving proof satisfactory to us that you sustain an accidental bodily injury in the performance of your occupation duties causing you to acquire and test positive for Hepatitis B or C within 365 days of the date of the accident, we will pay a monthly benefit. The portion of the AD&D full amount we will pay is listed below. The accident must occur while you are covered under the certificate for AD&D insurance benefit. A charge must be incurred for treatment of the accidental bodily injury.

The monthly benefit will be 0.8333% of the AD&D full amount. We will pay the monthly benefit for a maximum of 24 months.

In order to receive the Hepatitis B or C benefit, you must:

- submit a Workers' Compensation injury report to your employer within 72 hours of the accident; and
- submit to us a blood test for Hepatitis B or C which indicates negativity with respect to the presence of any antibodies or antigens to such disease within 72 hours of the accident.

If the initial blood test for Hepatitis B or C is negative and you subsequently test positive for Hepatitis B or C within 365 days of the accident, we will begin monthly payments.

[If you test positive for HIV and Hepatitis B or C as a result of the same occupational accident, only one benefit amount will be paid.]

The occupational Hepatitis B or C benefit will terminate on the earliest of the following dates:

- the date you die;
- the date you recover; or
- the date the last of the maximum number of installments is paid.

Benefits payable under this benefit reduce the full amount for the Accidental Death Insurance Benefit payable for death as the result of the same accident.]

Losses Not Covered Under the AD&D Insurance Benefit

This certificate does not cover any losses caused by, contributed to by, or resulting from:

- an attempt to commit or commission of suicide or intentional self-inflicted injury while sane or insane;
- active participation in a riot;
- an attempt to commit or commission of a felony or engaging in an illegal occupation;
- voluntary use of any drugs, poisonous substance, intoxicant or narcotic, except any drugs taken as prescribed by a physician and taken as prescribed. Accidental exposure to any poisonous substance will not be excluded;
- the presence of that percentage of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the accident occurred;
- disease of the body, mental infirmity or diagnostic, medical or surgical treatment; [or]
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release; or]

- [occupational injury [sustained by your covered spouse, if applicable]. **Occupational injury** means an injury that was caused by or aggravated by any employment for pay or profit or otherwise occurring within the course of employment[; or]]
- [travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned by or on behalf of your employer[; or]]
- [travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
 - it is being used for test or experimental purposes;
 - any covered person is operating, learning to operate or serving as a member of the crew; or
 - it is being operated by or for or under the direction of any military authority.

This exclusion does not apply to:

- transport type aircraft operated by the Military Airlift Command of the United States
- similar air transport service of any other country[; or]]
- [investigational or experimental procedures, surgery, or drugs, including complications arising from having experimental or investigative procedures, surgeries, or drugs].]

[SECTION [XII] – WAIVER OF PREMIUM

Waiver of Premium

Your insurance coverage on yourself, your covered spouse and dependent children, if applicable, may be continued for a specific time and your insurance premium will be waived if you are disabled for longer than the elimination period shown on the Certificate Schedule.

Elimination Period means a period of continuous disability shown on the Certificate Schedule which must be satisfied before you are eligible to have your premium waived by us.

When Waiver Begins

Your premium waiver will begin if the elimination period has ended and you meet the following conditions. The policyholder may continue premium payments until we notify them of the date your premium waiver begins.

Your premium will be waived if you meet these conditions:

- you are [less than 65 and] covered under this certificate when you become disabled;
- you become disabled and remain disabled during the elimination period;
- premiums are paid during the elimination period;
- you meet the notice and proof of loss requirements for disability while your coverage is in effect or within three months after it ends; and
- your claim is approved by us.

[You are disabled when we determine that:

- during the elimination period and the next [one year] after the elimination period, you are unable to perform any of the material and substantial duties of your regular occupation due to your injury or sickness and you are under the regular care of a physician.
- beyond the [one year] after the elimination period, you are also not working, and, due to the same injury or sickness, are unable to perform the duties of any gainful occupation for which you are reasonably fitted by training, education or experience, and you are under the regular care of a physician.

Regular occupation means the occupation you are routinely performing when your disability begins.

Material and substantial duties means duties that normally are required for the performance of your regular occupation; and cannot be reasonably omitted or modified.]

[You are disabled when we determine that:

- during the elimination period, you are not working in any occupation due to your injury or sickness and you are under the regular care of a physician; and

- after the elimination period, due to the same injury or sickness, you are unable to perform the material and substantial duties of any gainful occupation for which you are reasonably qualified by reason of training, education or experience, and you are under the regular care of a physician.

Material and substantial duties means duties that normally are required for the performance of the gainful occupation; and cannot be reasonably omitted or modified.

Gainful occupation means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.]

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under this certificate.

Sickness means an illness or disease. Disability must begin while you are covered under this certificate.

Regular Care means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition; and
- you are receiving appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition by a physician whose specialty or experience is the most appropriate for your disabling condition, according to generally accepted medical standards.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We do not require premium payments for you, your spouse and dependent children coverage when we approve your claim for premium waiver, or for the period premium is waived.

You may not apply for an increase in coverage while on waiver of premium.

Your insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

Proof of Loss - Waiver of Premium

If a claim is based on your disability, written notice and proof of loss must be sent no later than 90 days after the end of the elimination period. If you have a disability, you must notify us immediately when you return to work at any occupation.

If your claim is based on your disability, your proof of loss, provided at your expense, must show:

- that you are under the regular care of a physician;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing the material and substantial duties of [your regular occupation and] any gainful occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

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

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Colonial Life representative.

In some cases, you or your authorized representative will be required to give us authorization to obtain additional medical and non-medical information as part of your proof of continuing disability. We will deny your claim if the appropriate information is not submitted.

Waiver of Premium Claims

Your employer must complete a notification form which covers questions on waiver. You or your authorized representative must fill out your sections of the claim form and then give it to your attending physician. Your physician should fill out his section of the form and send it directly to us.

When Waiver Ends

The waiver of premium will automatically end if:

- you recover and are no longer disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by us; or
- you reach the end of the waiver duration period shown on the Certificate Schedule or your retirement date, whichever occurs first.

You will not be considered retired or reaching your retirement date if you are receiving disability payments under:

- the United States Social Security Act; or
- any similar law, plan or act; or
- your employer's retirement plan.

However, you will be considered retired if you are receiving retirement benefits.

Law, Plan or Act means the original enactments of the law, plan or act and all amendments.

Retirement plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by post tax or employee contributions, as that term is used in the Internal Revenue Code of 1986, as amended.

Waiver Application

Contact us for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.]

[SECTION [XIII] – PORTABILITY

Portable Coverage

If you cease to be a member of an eligible class as defined in the Policy Rate Schedule, you may apply for portable coverage for yourself and your covered spouse and dependent children, if applicable. Portable coverage becomes effective the date following the date you cease to be a member of an eligible class.

In case of your death, your covered spouse and dependent children, if applicable, also may apply for portable coverage for themselves. However, dependent children cannot become insured for portable coverage unless your covered spouse also becomes insured for portable coverage. If there is no spouse insured under this certificate, dependent children cannot become insured for portable coverage.

Portable Insurance Amounts

The portable insurance coverage will be the current coverage and amounts in force for each covered person under the policy when you apply for portable coverage.

However, the amount of portable coverage for you will not be more than the lesser of:

- the highest amount of Life [or AD&D] Insurance Benefit available for named insureds under the policy; or
- \$750,000 from all Colonial Life's group life [and AD&D] policies combined.

The amount of portable coverage for your spouse will not be more than the lesser of:

- the highest amount of Life [or AD&D] Insurance Benefit available for spouses under the policy; or
- \$750,000 from all Colonial Life's group life [and AD&D] policies combined.

The amount of portable coverage for a dependent child will not be more than the lesser of:

- the highest amount of Life [or AD&D] Insurance Benefit available for dependent children under the policy; or

- \$20,000.

[The amount of ported life insurance must be equal to the amount of ported AD&D insurance.]

In force amounts of insurance will reduce or cease at any time they would reduce or cease if you had remained a member of an eligible class.

Applying for Portable Coverage

You must apply for portable coverage and pay the first premium within 31 days after the date you are no longer a member of an eligible class.

[Portable coverage is subject to evidence of insurability.]

Your covered spouse and dependent children, if applicable, must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage if:

- [you have an injury or sickness under the terms of this certificate which has a material effect on life expectancy;]
- you have received benefits under the “Accelerated Death Benefit” provision;
- the policy is cancelled; or
- you failed to pay the required premium under the terms of this certificate.

[**Injury** means a bodily injury that is the direct result of an accident and not related to any other cause.

Sickness means an illness or disease.]

In addition, you are not eligible to apply for portable coverage for a covered spouse or dependent children if you do not apply for portable coverage for yourself.

In case of your death, your spouse and your dependent children are not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this certificate;
- [your surviving spouse has an injury or sickness under the terms of this certificate, which has a material effect on life expectancy;]
- the policy is cancelled; or
- the required premium under the terms of the policy for your covered spouse or your dependent children is not paid.

[If we determine that because of an injury or sickness, you, your covered spouse, or your dependent children were not eligible for portability at the time you, your covered spouse, or your dependent children elected portable coverage, you will need to complete a conversion application to qualify for a conversion policy.]

If any of the statements you make in applying for portable coverage are not complete and true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your portable coverage from the date it began.

We cannot take this action after your portable coverage has been in effect during the lifetime of the covered person for two years.

Increases or Decreases in Portable Coverage

We will allow certain increases or decreases in the amount of coverage. The maximum benefit amounts are shown on the Policy Rate Schedule. However, the amount of coverage cannot be decreased below \$5,000 for you and your covered spouse and \$1,000 for your dependent children. [You may not increase coverage for your spouse and dependent children.] Increases may be subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the benefit reduction due to age schedule in the “Life Insurance Benefit” provision [and the “Accidental Death & Dismemberment (AD&D) Insurance Benefit” provision].

Adding Portable Coverage for Spouse and Dependent Children

If you chose not to enroll your covered spouse or dependent children when they were first eligible for portable coverage, you may apply for coverage for them at any time for the amounts allowed under the policy.

You may apply for portable coverage for a newly acquired spouse or dependent child within 31 days of a family status change for the amounts allowed under the policy without evidence of insurability. Any amount over the guaranteed issue amount will be subject to evidence of insurability.

When Portable Coverage Ends

Portable coverage will end on the date any required premium is not paid by the end of the grace period.

In addition, portable coverage for your spouse or dependent children will end on:

- the date your surviving spouse fails to pay any required premium by the end of the grace period;
- the date your dependent child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

Premiums for Portable Coverage

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premiums are based on the rates in effect on any premium due date.

Grace Period (If Premiums Are Not Paid When Due) for Portable Coverage

After the first premium, if the premium is not paid when it is due, it can be paid during the next [31] days. These [31] days are called the **grace period**. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this certificate will terminate at the end of the grace period.

Premium Rate Changes for Portable Coverage

We may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all covered persons;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to our underwriting risk studies. We will notify you at least [60] days before a premium rate is changed.

If Portable Coverage Ends or Is Not Available

If a covered person is not eligible to apply for portable coverage or portable coverage ends, then a covered person may qualify for conversion coverage. Refer to "Conversion Privilege for Life Insurance" under this certificate.]

SECTION [XIV] – CONVERSION PRIVILEGE FOR LIFE INSURANCE

Conversion When Your Coverage Ends

Provided you have not reached the policy anniversary date on or following your attaining age 85, when coverage ends under this certificate, you can convert to individual life coverage. Evidence of insurability will not be required. The maximum amount you can convert is the amount of life insurance in force under the certificate. You may convert a lower amount of life insurance.

If your spouse is covered under the "Life Insurance Benefit" of this certificate, provided your spouse has not reached the policy anniversary date on or following his attaining age 85, when coverage ends, he may convert to individual life coverage. Evidence of insurability will not be required. If your dependent children are covered under the "Life Insurance Benefit" of this certificate, when coverage ends, they may convert to individual life coverage without evidence of insurability. If the dependent child who converts has not reached the age of majority, the owner of the converted policy shall be the surviving parent or legal guardian of the child.

A covered person must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the earlier of the following dates:

- the date you cease to be a member of an eligible class; or
- the date a covered person is no longer eligible to participate in the coverage of the policy.

If you convert to an individual life policy, then again become a member of an eligible class and again become insured under the policy, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you again become a member of an eligible class.

Converted insurance shall be a level premium whole life policy then in use by us. The individual policy will not contain waiver of premium, AD&D or other extra benefits.

Policyholder Notice

The policyholder must notify you of your conversion privileges within 15 days from the date your life insurance terminates.

If the policyholder does not notify you within those 15 days, but does notify you within 90 days from the date your life insurance terminates, the time allowed for you to exercise your life conversion privilege will be extended 15 days from the date you are notified.

If the policyholder does not notify you within those 90 days, the time allowed for you to exercise your life conversion privilege will expire at the end of those 90 days.

Conversion If Plan Is Cancelled

A covered person may convert a limited amount of life insurance if you have been insured under the policy with us for at least five years and the policy:

- is cancelled with us; or
- changes so that you no longer are eligible.

The individual life policy maximum for each covered person will be the lesser of:

- \$10,000; or
- the coverage amounts under the policy less any amounts that become available under any other group life policy offered by the policyholder within 31 days after the date the policy is cancelled.

Premiums for Converted Insurance

Premiums for the converted insurance will be based on:

- the covered person's then attained age on the effective date of the individual life policy;
- the amount of insurance to be converted;
- our customary rates in use at that time; and
- the class of risk to which the covered person belongs.

If the covered person applies for the individual life insurance policy and pays the first premium within 31 days, as provided above, the individual life insurance policy will be effective at the end of the 31-day conversion application period.

If Death Occurs During the Conversion Application Period

If a covered person dies within the 31-day conversion application period, we will pay the beneficiary the amount of insurance that could have been converted. This coverage is available whether or not a covered person has applied for an individual life policy under the conversion privilege.

Applying for Conversion

Ask the policyholder or us for a conversion application form. When you complete the application, send it with the first premium amount to:

Colonial Life & Accident Insurance Company
P.O. Box 1365
Columbia, SC 29202

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202
APPLICATION FOR GROUP TERM LIFE INSURANCE**

POLICYHOLDER SECTION:	
Policyholder Name ABC Company	Billing Control Number E5555555
Policyholder Home Office (or Corporate) Address Street City State Zip Code 345 Any Street Any City Any State 12345	Policyholder Phone Number 555-555-5555
Do you have eligible employees located in other states? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," list states here:	Plan Administrator Name Betty Planadmin
Nature of Business Any	Policy Effective Date (mm/dd/yyyy) 06/01/2011

ENROLLMENT INFORMATION:	
Initial Enrollment Dates Start Date (mm/dd/yyyy) - Stop Date (mm/dd/yyyy) 04/01/2011 - 05/01/2011	Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and Colonial Life & Accident Insurance Company each year.
Eligible Class: <input checked="" type="checkbox"/> All employees in active employment working at least ___[20]___ hours per week. <input type="checkbox"/> Other: [_____]	
Number of Eligible Employees: [__xx__] Waiting Period:[__xx__] Days Eligibility Period: [__xx__] Days	

REPLACEMENT SECTION:	
Is this a replacement of similar coverage? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, a copy of the previous carrier's plan is required.	
Previous Company Name	Termination Date of Prior Plan

LIFE COVERAGE - CHOOSE ONLY ONE PLAN AND APPLICABLE OPTION(S):	
The policyholder must choose between the plans listed below. The options chosen must agree with Colonial Life's underwriting requirements for this product unless agreed upon in advance.	
<input checked="" type="checkbox"/> Voluntary Term Life Insurance (Employee Paid)	
Employee Coverage: <input checked="" type="checkbox"/> Incremental plan (\$10,000 minimum, \$1,000 increments) OR <input type="checkbox"/> Multiple of Salary: _____ (multiples of salary should be in [.50 increments to a maximum of five times annual salary, select up to five choices])	
Spouse Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No (\$5,000 minimum, \$1,000 increments, cannot exceed employee amount) Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No (\$1,000 minimum, \$1,000 increments, [\$20,000 maximum])	
Plan (choose only one): <input checked="" type="checkbox"/> Group Term Life Only <input type="checkbox"/> Group Term Life with Accidental Death & Dismemberment <input type="checkbox"/> Group Term Life with Waiver of Premium <input type="checkbox"/> Group Term Life with Waiver of Premium and Accidental Death & Dismemberment For plans that include Waiver of Premium also complete the Custom Plan section.	[If AD&D is selected, choose up to two suites. <input type="checkbox"/> Catastrophic Suite <input type="checkbox"/> Family Suite <input type="checkbox"/> Malicious Intent Suite <input type="checkbox"/> Occupational Disease Suite <input type="checkbox"/> Travel Suite <input type="checkbox"/> None]] If two suites chosen for Voluntary coverage, the employee will choose one of the two suites.

CUSTOM PLANS ONLY:

Rate Guarantee: [_____] years

 Tobacco distinct rates
 Uni-Tobacco ratesContinuation of Coverage:
 Yes No

Waiver of Premium, select:

Elimination Period days: 90 120 180 270 360Benefit Period – Duration of Disability: Age 65 Age 70 ADEA 1Definition of Disability: Any occupation 1 year own occupation 2 years own occupation

Portability, select:

Without E of I Yes No

Other: [_____]

AGREEMENT SECTION

All statements and information found in the application are deemed representations and not warranties. Any person who knowingly presents a false or fraudulent claim for payment for 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. It is understood and agreed that this application shall be attached as a part of the Policy applied for and that no Insurance shall be effective until approved by Colonial Life & Accident Insurance Company at its Home Office.

Signed at: City Any City State Any Date 04/01/2011
mm/dd/yyyy(x) Jack Employer
(Authorized Signature/Title)**AGENT SECTION**

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance policy in detail; and (d) to the best of my knowledge and belief the proposed Policyholder is financially sound.

(x) John R. Agent License No. 12345 Code No. 67890
Signature of Licensed Agent

Fraud Warning Notice

For all states except those listed below:	Any person who knowingly and with the 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.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	All statements and information found in the application are deemed representations and not warranties. 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.
Kentucky, Kansas and North Carolina	Any person who knowingly and with the 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 may subject such person to criminal and civil penalties.
Maine 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 may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
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.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	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. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. <u>Penalties include imprisonment, fines and denial of coverage.</u>
Virginia	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 may have violated state law.

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202
ENROLLMENT FORM - GROUP TERM LIFE INSURANCE**

Application Type: <input checked="" type="checkbox"/> Initial Request <input type="checkbox"/> Late Applicant <input type="checkbox"/> Rehire <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Change in Status <input type="checkbox"/> Increase		
Note: If you DO NOT ENROLL for coverage for you or your dependent(s) during the initial enrollment period, and / or you apply for coverage over any Guaranteed Issue amount, you will need to complete the Evidence of Insurability form.		

SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always complete					
Proposed Insured Name (First, MI, Last) John A. Doe			Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy) 01/01/1966	Social Security No. 111-11-1111
Home Address – Street 123 Any Street		City Any City	State Any State	Zip Code 12345	Employee ID/Payroll No. 111-11-1111
Email Address anymail@anywhere.com				Home Phone No. (555)555-5555 Business Phone No. (555)555-5555	
Date Employed 01/01/2009	Occupation/Job Title Any	Annual Base Salary \$50,000	Hrs. Worked/Week 40	Employee Class	
Employer Name ABC Company		Employer Address (Street-City-State-Zip) 345 Any Street, Any City, Any State 12345			Section/Dept. No.

SECTION 2: COVERAGE INFORMATION – Always complete			
Coverage Elections	Plan Code	Face Amount	Monthly Premium
<input checked="" type="checkbox"/> Employee If multiple of salary, indicate multiple selected _____	xxxx	\$xx,xxx	\$xx.xx
<input type="checkbox"/> Spouse			
<input type="checkbox"/> Dependent Children			
Is a suite being applied for? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Rider Plan Code: __xxxx__			\$xx.xx
			Total Premium \$xx.xx

SECTION 3: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage				
Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			

SECTION 4: BENEFICIARY INFORMATION – Employee only					
Beneficiary's Name (First, MI, Last) Jane A. Doe	Primary <input checked="" type="checkbox"/> Contingent <input type="checkbox"/>	Age 40	Benefit % 100	Relationship to Proposed Insured Wife	Social Security No. 222-22-2222
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 5: ELIGIBILITY INFORMATION – Required for Guaranteed Issue and all levels of underwriting

	Proposed Insured	Your Spouse
1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
2. Are you actively working? If "No", are you disabled or unable to work?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Is your spouse (if applying for coverage) disabled or unable to work?		Yes <input type="checkbox"/> No <input type="checkbox"/>

AGREEMENT SECTION**THE PROPOSED INSURED AGREES AS FOLLOWS:**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I confirm I have read and understand the Fraud Statement attached. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the policy or certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy or certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the application.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City Any City State Any Date 04/01/2011
mm/dd/yyyy

(x) John D. Doe
Signature of Proposed Insured

AGENT SECTION

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date 04/01/2011 (x) Joe R. Agent
mm/dd/yyyy Signature of Licensed Agent (if applicable)

Agent Name Joe R. Agent License No. 12345 Code No. 67890

Fraud Warning Notice

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Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	All statements and information found in the application are deemed representations and not warranties. 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.
Kentucky, Kansas and North Carolina	Any person who knowingly and with the 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 may subject such person to criminal and civil penalties.
Maine 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 may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
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.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	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. If coverage is contested, the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia	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 may have violated state law.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202

**ENROLLMENT FORM / EVIDENCE OF INSURABILITY
GROUP TERM LIFE INSURANCE**

Application Type: <input checked="" type="checkbox"/> Initial Request	<input type="checkbox"/> Late Applicant	<input type="checkbox"/> Rehire	<input type="checkbox"/> Portability
<input type="checkbox"/> Annual Enrollment	<input type="checkbox"/> Change in Status	<input type="checkbox"/> Increase	

SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always complete					
Proposed Insured Name (First, MI, Last) John A. Doe		Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy) 01/01/1966	Social Security No. 111-11-1111	
Home Address – Street 123 Any Street		City Any City	State Any State	Zip Code 12345	Employee ID/Payroll No. 111-11-1111
Email Address anymail@anywhere.com		State of Birth	Home Phone No. (555)555-5555 Business Phone No. (555)555-5555		
Date Employed 01/01/2009	Occupation/Job Title Any	Annual Base Salary \$50,000	Hrs. Worked/Week 40	Employee Class	
Employer Name ABC Company		Employer Address (Street-City-State-Zip) 345 Any Street, Any City, Any State 12345			Section/Dept. No.

SECTION 2: COVERAGE INFORMATION – Always complete			
Coverage Elections	Plan Code	Face Amount	Monthly Premium
<input checked="" type="checkbox"/> Employee If multiple of salary, indicate multiple selected _____	xxxx	\$xx,xxx	\$xx.xx
<input type="checkbox"/> Spouse			
<input type="checkbox"/> Dependent Children			
Is a suite being applied for? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Rider Plan Code: __xxxx__			\$x.xx
			Total Premium \$xx.xx

SECTION 3: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage. Height and weight is required for spouse only.						
Name (First, MI, Last)	Gender	HT	WT	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M <input type="checkbox"/> F <input type="checkbox"/>					
	M <input type="checkbox"/> F <input type="checkbox"/>					
	M <input type="checkbox"/> F <input type="checkbox"/>					
	M <input type="checkbox"/> F <input type="checkbox"/>					
	M <input type="checkbox"/> F <input type="checkbox"/>					

SECTION 4: BENEFICIARY INFORMATION – Employee only					
Beneficiary's Name (First, MI, Last) Jane A. Doe	Primary <input checked="" type="checkbox"/> Contingent <input type="checkbox"/>	Age 40	Benefit % 100	Relationship to Proposed Insured Wife	Social Security No. 222-22-2222
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 5: ELIGIBILITY INFORMATION – Required for Guaranteed Issue and all levels of underwriting		
	Proposed Insured	Spouse
1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
2. Are you actively working? If "No", are you disabled or unable to work?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Is your spouse (if applying for coverage) disabled or unable to work?		

SECTION 6: EVIDENCE OF INSURABILITY (complete if required)		
If you answer yes to any question please provide details on the following page.	Proposed Insured	Spouse
4. (Employee only) Indicate Your Current: Height__5'10____ Weight__185____		
5. Has any proposed insured tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 7 years has any proposed insured ever received medical advice or sought treatment by a member of the medical profession (including medication) for any condition listed below? If yes, provide details. Circulatory, Heart, Blood Vessel Disease or Disorder Heart Murmur Cancer or Tumor, including leukemia or melanoma Heart Attack (MI) Blood Disease or Lymph Node Disorder Diabetes Skin, Bone, Muscle or Joint Disorder Chest Pain / Angina Asthma, Emphysema, Lung or Respiratory Disorder High Blood Pressure Gastrointestinal or Digestive Disease or Disorder Liver Disease or Disorder Kidney or Genitourinary Disease or Disorder Nervous or Mental Disorder Stroke Paralysis Epilepsy Thyroid Disorder	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Within the past 24 months, has any proposed insured engaged in hang gliding, mountain climbing, flying ultralights, parachuting, sky diving, ballooning, flown as a student or private pilot, engaged in auto, motorcycle or boat racing, scuba diving to depths greater than 75 feet; or participated in any other similar sport or avocation? If yes, provide details.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Within the past 5 years, has any proposed insured had their driver's license revoked or suspended for any reason; been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to or been convicted of 3 or more speeding or other moving violations? If yes, provide details, including person's name, type of violation(s), date(s), driver's license number and state.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Has any proposed insured ever used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed by a member of the medical profession; received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession to reduce the consumption of drugs or alcohol? If yes, provide details including the frequency of use and the date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's / hospital / facility name, address and phone number.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Has any proposed insured ever pled guilty to, pled no contest to, have a charge pending or been convicted of a felony or misdemeanor? If yes, list the person's name, reason for arrest, date and indicate if the person is on probation, parole or incarcerated.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Within the past 5 years, has any proposed insured been confined to a hospital or medical facility, seen a member of the medical profession for any reason other than stated on this application, or are currently taking medication or receiving medical advice by a member of the medical profession? If yes, provide details.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 6: DETAILS FOR ANY "YES" ANSWERS IN SECTION 5

Name	Detailed Description	Date	Duration	Treatment Received	Name & Address of Physician / Hospital

ADDITIONAL DATA SECTION

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

For the purpose of evaluating my application(s) for insurance submitted during the current enrollment and eligibility for benefits under any insurance issued including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application(s), I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Non-health information including earnings or employment history deemed appropriate by Colonial Life to evaluate my application may be disclosed by any person or organization that has these records about me, including my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating my application(s) for insurance or eligibility for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution and a copy is as valid as the original. A copy will be included with my contract(s) and I or my authorized representative may request access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract(s) or the contract itself. If revoked, Colonial Life may not be able to evaluate my application(s) for insurance or eligibility for benefits as necessary to issue my contract(s). I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Underwriting Department, P.O. Box 1365, Columbia, SC 29202.

You may refuse to sign this form; however, Colonial Life may not be able to issue your coverage. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, or Conservator.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I confirm I have read and understand the Fraud Statement attached. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company until both: 1) the policy or certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy or certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the application.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB. I elect to be interviewed if any investigative consumer report is prepared in connection with this application. Yes No

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City Any City State Any Date 04/01/2011
mm/dd/yyyy

(x) John D. Doe (x) _____
Signature of Proposed Insured Signature of Spouse

AGENT SECTION

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date 04/01/2011 (x) Joe R. Agent
mm/dd/yyyy Signature of Licensed Agent (if applicable)

Agent Name Joe R. Agent License No. 12345 Code No. 67890

Fraud Warning Notice

For all states except those listed below:	Any person who knowingly and with the 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.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	All statements and information found in the application are deemed representations and not warranties. 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.
Kentucky, Kansas and North Carolina	Any person who knowingly and with the 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 may subject such person to criminal and civil penalties.
Maine 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 may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
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.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	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. If coverage is contested, the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia	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 may have violated state law.

**ELECTION OF PORTABILITY COVERAGE – GROUP TERM LIFE INSURANCE AND AD&D COVERAGE
 COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
 PO BOX 1365 COLUMBIA, SOUTH CAROLINA 29202**

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable coverage. To apply you must complete this form and send it to us within 31 days after your group life insurance coverage ends. If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage. Ask the policyholder for a conversion application form (which includes cost information). **You may not be eligible for portable coverage if you have an injury or sickness that has a material effect on life expectancy. Your spouse of any dependent child who has a medical condition that has a material effect on life expectancy may not be eligible for portable coverage. Also, Evidence of Insurability may be required.**

Please obtain your portability premium rates from your plan administrator and mail your initial premium payment, along with this election form, to the address shown above. **Make your check or money order payable to Colonial Life & Accident Insurance Company.**

SECTION 1: EMPLOYER INFORMATION (to be completed by the employer)			
Policyholder Name ABC Company	Group Policy Number E5555555	Billing Control Number E5555555	
Policyholder Home Office Address - Street 345 Any Street	City Any City	State Any State	Zip Code 12345
Business Phone No. 555-555-5555	Reason for Termination / Reduction Job change		Date of Termination: mm/dd/yyyy 03/15/2011
Is portability guaranteed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Policyholder Signature	
(x) <u>Jack Employer</u> Employer / Plan Administrator		Date: <u>04/01/2011</u> mm/dd/yyyy	

SECTION 2: APPLICANT INFORMATION (to be completed by the applicant)			
Insured Name (First, MI, Last) John D Doe	Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy) 01/01/1966	Social Security No. 111-11-1111
Home Address – Street 123 Any Street	City Any City	State Any State	Zip Code 12345
Home Phone No. 555-555-5555	Email Address anyemail@anywhere.com		Business Phone No. 555-555-5555
Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Within the past 12 months have you submitted evidence of insurability to Colonial Life for group coverage?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

You may keep the same level of coverage or decrease coverage. You may also increase coverage (for you) or add dependent(s) (if your policyholder's plan has spouse or dependent children coverage) subject to medical evidence of insurability. **If you increase coverage or add dependent(s) a separate evidence of insurability form must be completed.**

NOTE: For specific plan maximums/minimums, rounding rules and reduction formulas refer to your plan administrator. If you have any questions concerning your or your dependent's eligibility for portability coverage, please contact us at 1-800-845-7330. If no dependent or AD&D coverage is available under your group plan, then any reference to "dependent" or "AD&D" is not applicable.

SECTION 3: COVERAGE ELECTIONS – The employee must port coverage, if applicable, in order for any eligible spouse or dependent children to be eligible to port.		Face Amount	Monthly Premium
<input checked="" type="checkbox"/> Employee	No change <input checked="" type="checkbox"/> Decrease <input type="checkbox"/>	\$xx,xxx	\$xx.xx
<input type="checkbox"/> Spouse	No change <input type="checkbox"/> Decrease <input type="checkbox"/>	\$	\$
<input type="checkbox"/> Dependent Children	No change <input type="checkbox"/> Decrease <input type="checkbox"/>	\$	\$
Is AD&D coverage being ported? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Total Monthly Premium	\$xx.xx
Select a premium payment option:	<input checked="" type="checkbox"/> Bank Draft (monthly premium) <input type="checkbox"/> Semi-Annually (monthly premium x6)	<input type="checkbox"/> Quarterly (monthly x3) <input type="checkbox"/> Annually (monthly premium x12)	

SECTION 4: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if porting spouse and/or dependent children coverage				
Name (First, MI, Last)	Gender	Birthdate(mm/dd/yyyy)	Relationship	Social Security No.
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			

SECTION 5: EMPLOYEE BENEFICIARY INFORMATION – if completed this beneficiary designation will replace any current beneficiary designation on file with us.					
Beneficiary's Name (First, MI, Last) Sally A Doe	Primary <input checked="" type="checkbox"/> Contingent <input type="checkbox"/>	Age 40	Benefit % 100	Relationship to Proposed Insured Wife	Social Security No. 222-22-2222
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 6: EVIDENCE OF INSURABILITY (required if Portability is not guaranteed and you are not increasing coverage or adding a spouse / dependent)		
If you answer yes to any question please provide details on the following page.	Proposed Insured	Spouse
1. (Employee only) Indicate Your Current: Height__5'10____ Weight__185____		
2. Does any proposed insured have a medical condition which has a material effect on life expectancy, including, but not limited to, heart or cardiovascular disease or impairment, cancer or tumor, lung or respiratory disorder, kidney or genitourinary disorder, digestive disorder, diabetes, mental, nervous or nervous system disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Within the past 5 years, has any proposed insured been confined to a hospital or medical facility, seen a member of the medical profession for any reason other than stated on this application, or are currently taking medication or receiving medical advice by a member of the medical profession?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Within the past 3 years, has any proposed insured used illegal or illicit drugs, received 3 or more speeding tickets or moving violations, been charged with driving while intoxicated, or pled guilty to, pled no contest to, have a charge pending or been convicted of a felony or misdemeanor?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 7: DETAILS FOR ANY "YES" ANSWERS IN SECTION 6

Name	Detailed Description	Date	Duration	Treatment Received	Name & Address of Physician / Hospital

I understand and agree to the following:

1. Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Colonial Life group term life insurance coverage under which this coverage is offered and is subject to satisfaction of the conditions provided therein. Evidence of Insurability and/or additional information may be required.
2. Portability coverage will become effective the day after the group coverage terminates subject to Colonial Life receiving a completed election form and the first premium within 31 days from the date group coverage terminates.

John K. Doe
Applicant/Employee Signature

04/01/2011
Date (mm/dd/yyyy)

POLICY AMENDMENT NO. [000]

This amendment forms a part of the Policy No. [000-0] issued to the Policyholder:

[JOHN DOE COMPANY]

The Policy is changed to read as follows:

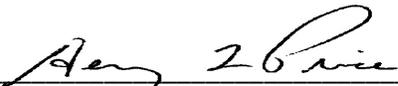
The Policy is revised based on the changes listed below:

The effective date of these changes is mm/dd/yyyy. The changes only apply to deaths [and covered losses] [and disabilities] which start on or after the effective date. Claims for deaths, [and covered losses] [and disabilities] that occur prior to mm/dd/yyyy will be determined according to the Policy in effect prior to this amendment.

The Policy terms and provisions will apply other than as stated in this amendment.

All other terms, conditions and provisions of the policy remain unchanged.

Colonial Life & Accident Insurance Company

By: 
Senior Vice President

CERTIFICATE AMENDMENT

The changes shown below are made a part of the certificate which was issued to you under the terms of the Policy issued to:

[JOHN DOE COMPANY]

Group Policy No [000-0]

Certificate No [000-0]

The Certificate is changed to read as follows:

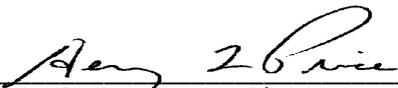
The effective date of these changes is mm/dd/yyyy or the effective date of your certificate, whichever is later.

The changes only apply to death [and covered losses] [and disabilities] which start on or after the effective date. Claims for death, [and covered losses] [and disabilities] that occur prior to mm/dd/yyyy will be determined according to the Certificate in effect prior to this rider.

All other terms and provisions of the certificate remain unchanged.

Dated at Columbia, SC this [] day of []

Colonial Life & Accident Insurance Company

By: 
Senior Vice President

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202
APPLICATION FOR GROUP TERM LIFE INSURANCE**

POLICYHOLDER SECTION:	
Policyholder Name ABC Company	Billing Control Number E5555555
Policyholder Home Office (or Corporate) Address Street City State Zip Code 345 Any Street Any City Any State 12345	Policyholder Phone Number 555-555-5555
Do you have eligible employees located in other states? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," list states here:	Plan Administrator Name Betty Planadmin
Nature of Business Any	Policy Effective Date (mm/dd/yyyy) 06/01/2011

ENROLLMENT INFORMATION:	
Initial Enrollment Dates Start Date (mm/dd/yyyy) - Stop Date (mm/dd/yyyy) 04/01/2011 - 05/01/2011	Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and Colonial Life & Accident Insurance Company each year.
Eligible Class: <input checked="" type="checkbox"/> All employees in active employment working at least ___[20]___ hours per week. <input type="checkbox"/> Other: [_____]	
Number of Eligible Employees: [__xx__] Waiting Period:[__xx__] Days Eligibility Period: [__xx__] Days	

REPLACEMENT SECTION:	
Is this a replacement of similar coverage? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, a copy of the previous carrier's plan is required.	
Previous Company Name	Termination Date of Prior Plan

LIFE COVERAGE - CHOOSE ONLY ONE PLAN AND APPLICABLE OPTION(S):	
The policyholder must choose between the plans listed below. The options chosen must agree with Colonial Life's underwriting requirements for this product unless agreed upon in advance.	
<input type="checkbox"/> Basic Term Life Insurance (Employer Paid)	
Employer Paid % <input checked="" type="checkbox"/> [100%] <input type="checkbox"/> [75%] <input type="checkbox"/> [50%] <input type="checkbox"/> [Other:_____%]	
Employee coverage only: <input checked="" type="checkbox"/> Flat Amount of Coverage: \$_xx,xxx_____ (\$10,000 minimum, \$1,000 increments) OR <input type="checkbox"/> Multiple of Salary: _____ to a maximum amount of: \$_____ (multiples of salary should be in [.50 increments to a maximum of five times annual salary])	
Plan (choose only one): <input type="checkbox"/> Group Term Life Only <input checked="" type="checkbox"/> Group Term Life with Accidental Death & Dismemberment <input type="checkbox"/> Group Term Life with Waiver of Premium <input type="checkbox"/> Group Term Life with Waiver of Premium and Accidental Death & Dismemberment For plans that include Waiver of Premium also complete the Custom Plan section.	[If AD&D is selected, choose up to one suite. <input type="checkbox"/> Catastrophic Suite] <input type="checkbox"/> Family Suite] <input checked="" type="checkbox"/> Malicious Intent Suite] <input type="checkbox"/> Occupational Disease Suite] <input type="checkbox"/> Travel Suite] <input type="checkbox"/> None]]

Basic Term Life Insurance (Employer Paid) and Supplemental Term Life Insurance (Employee Paid)

Employer Paid % [100%] [75%] [50%] [Other: _____ %]

Basic Term Life (employee coverage only):

- Flat Amount of Coverage: \$ _____ (\$10,000 minimum, \$1,000 increments) **OR**
- Multiple of Salary: _____ to a maximum amount of: \$ _____
(multiples of salary should be in [.50 increments to a maximum of five times annual salary])

AND

Supplemental Term Life:

- Incremental plan (\$10,000 minimum, \$1,000 increments) **OR**
- Multiple of Salary: _____
(multiples of salary should be in [.50 increments to a maximum of five times annual salary, select up to five choices])

Spouse Coverage: Yes No (\$5,000 minimum, \$1,000 increments, cannot exceed employee amount)
Dependent Children: Yes No (\$1,000 minimum, \$1,000 increments, [\$20,000 maximum])

Plan (choose one each for Basic and Supplemental):

Basic Supplemental

- Group Term Life Only
- Group Term Life with Accidental Death & Dismemberment
- Group Term Life with Waiver of Premium
- Group Term Life with Waiver of Premium and Accidental Death & Dismemberment

For plans that include Waiver of Premium also complete the Custom Plan section.

[If AD&D is selected, choose up to one suite for Basic and up to two suites for Supplemental:

Basic Supplemental

- [Catastrophic Suite]
- [Family Suite]
- [Malicious Intent Suite]
- [Occupational Disease Suite]
- [Travel Suite]
- [None]

If two suites chosen for Supplemental coverage, the employee will choose one of the two suites.

CUSTOM PLANS ONLY:

Rate Guarantee: [_____] years

- Tobacco distinct rates
- Uni-Tobacco rates

Continuation of Coverage:
 Yes No

Waiver of Premium, select:

- Elimination Period days: 90 120 180 270 360
- Benefit Period – Duration of Disability: Age 65 Age 70 ADEA 1
- Definition of Disability: Any occupation 1 year own occupation 2 years own occupation

Portability, select:

Without E of I Yes No

Other: [_____]

AGREEMENT SECTION

All statements and information found in the application are deemed representations and not warranties. Any person who knowingly presents a false or fraudulent claim for payment for 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. It is understood and agreed that this application shall be attached as a part of the Policy applied for and that no Insurance shall be effective until approved by Colonial Life & Accident Insurance Company at its Home Office.

Signed at: City Any City State Any Date 04/01/2011
mm/dd/yyyy

(x) Jack Employer
(Authorized Signature/Title)

AGENT SECTION

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance policy in detail; and (d) to the best of my knowledge and belief the proposed Policyholder is financially sound.

(x) John R. Agent License No. 12345 Code No. 67890
Signature of Licensed Agent

Fraud Warning Notice

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Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
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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.
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Maine 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 may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
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.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	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. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid.
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Virginia	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 may have violated state law.

SERFF Tracking Number: UNUM-127084886 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 49338
 Company Tracking Number: GROUP TERM LIFE 1.0
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: GTL1.0
 Project Name/Number: Group Term Life 1.0/Group Term Life 1.0

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

READABILITY COMPLIANCE CERTIFICATION.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The Applications have been added under the Form Schedule Tab.

Item Status: **Status Date:**

Satisfied - Item: Accelerated Death Benefit Disclosure Form

Comments:

Attachment:

GTL 1-0 - Accelerated Death Benefit Form - reg.pdf

Item Status: **Status Date:**

Satisfied - Item: Statements of Variability

Comments:

Attachments:

GTL1.0 Statement of Variability-Contract.pdf

GTL1 0 Forms Statement of Variability B-S Master.pdf

GTL1 0 Forms Statement of Variability V Master.pdf

Item Status: **Status Date:**

SERFF Tracking Number: UNUM-127084886 State: Arkansas
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 49338
Company Tracking Number: GROUP TERM LIFE 1.0
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: GTL1.0
Project Name/Number: Group Term Life 1.0/Group Term Life 1.0
Satisfied - Item: Annual Earnings Definitions

Comments:

Attachment:

Annual Earnings Definitions.pdf

Item Status:

Status

Date:

Satisfied - Item: Actuarial Memorandums

Comments:

Attachments:

GTL1.0 Actuarial Memorandum-AR.pdf

GTL1.0 AccelDeathBen-AM-AR.pdf

READABILITY COMPLIANCE CERTIFICATION

<u>Form No.</u>	<u>Flesch Score</u>
GTL 1.0-C-AR	50.7
GTL 1.0-P-AR	51.3

This is to certify that the attached Forms (listed above) have achieved the above Flesch Reading Ease Score and comply with the requirements of Arkansas Stat. Ann. § §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

7/18/2011

Date



Annette B. Smith
Senior Compliance Contract Consultant

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

REQUIRED DISCLOSURE FORM FOR ACCELERATED DEATH BENEFIT

Consequences of This Benefit:

Receipt of accelerated death benefits MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME (“SSI”) ELIGIBILITY. The mere fact that you have life coverage and own a certificate with an accelerated death benefit may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

<p>Medical condition allowing the Accelerated Death Benefit</p>	<p>An Accelerated Death Benefit is a benefit that allows you, the named insured, to be advanced a portion of the death benefit if the covered person is diagnosed with a terminal illness after the coverage effective date. <i>Terminal Illness</i> means an injury or sickness which results in the covered person having a life expectancy of 12 months or less and from which there is no reasonable prospect for recovery.</p> <p>This Disclosure Form highlights some of the information in Policy Form Group Term Life 1.0. It is not an insurance contract. If there are any inconsistencies between this disclosure form and the policy, then the terms and conditions of the actual policy will control.</p>
<p>Benefit Amount</p>	<p>You may request an amount of up to 75% of the certificate life coverage face amount, but not greater than \$150,000. The minimum Accelerated Death Benefit payment is \$5,000. The certificate must be in force on the date of payment and must have a life coverage face amount of at least \$10,000. The Accelerated Death Benefit amount payable to you is reduced:</p> <ul style="list-style-type: none"> • first by any due but unpaid premiums; then • by the administrative fee charged by us for Accelerated Death Benefit payments, in the amount in effect at the time of payment, not to exceed \$200; then • the remaining sum is discounted for a time period of one year using an interest rate no greater than the greater of: (a) the current yield on 90 day treasury bills; or (b) the current maximum statutory adjustable policy loan interest rate.
<p>To File a Claim</p>	<p>The Accelerated Death Benefit will be paid to you during the covered person’s lifetime while the certificate is in force, upon receipt of all of the following:</p> <ol style="list-style-type: none"> 1. a completed Accelerated Death Benefit request form; and 2. proof that the covered person has been diagnosed with a terminal illness. Such proof will include a statement from the covered person’s licensed physician, and any other medical information we deem necessary to confirm the covered person’s health status; and 3. written consent of any irrevocable beneficiary or any assignee, if applicable, agreeing that you may elect the death benefit advance.
<p>Benefit Payment</p>	<p>We will pay the Accelerated Death Benefit in a lump sum. Upon payment of the Accelerated Death Benefit, the life coverage face amount of the certificate will be reduced by the amount of Accelerated Death Benefit requested by you.</p>
<p>Taxability of Benefits</p>	<p>The amount paid under this benefit may be taxable. We are not responsible for any tax on or other effects of any benefit paid. As with all tax matters, consult your personal tax advisor to assess the impact of this benefit.</p>
<p>Effect on Benefits</p>	<p>The death benefit will be reduced if you file for and receive an Accelerated Death Benefit.</p> <p>If an Accelerated Death Benefit is paid, the certificate may not be converted and no new coverage can be added to the certificate.</p>

Example to show results of exercising the Accelerated Death Benefit on a \$100,000 life coverage face amount.

1. Death Benefit of certificate before Death Benefit is advanced	
Life Coverage Face Amount	\$100,000
2. Benefit Calculation based upon application for this benefit:	
Amount of Face Amount requested to be advanced	\$75,000
Less adjustments:	
any due but unpaid premiums	(\$ 0)
administrative fee	(\$200)
Net benefit prior to discounting	\$74,800
Interest rate used to discount accelerated payment*	6.00%
Discount factor	0.943397
Amount of Accelerated Death Benefit	\$70,566
3. Status of benefits on the Date of Payment of Accelerated Death Benefit:	
Remaining Death Benefit	\$25,000

*Will vary based on current yield on 90-day treasury bills.

Signature of Named Insured

Signature of Agent

Date signed (MM/DD/YYYY)

Named Insured Social Security Number

Statement of Variability for forms: GTL1.0-P and GTL1.0-C, including state variations where applicable

MASTER POLICY, GTL1.0-P

SECTION I: FACE PAGE

1. Our company address, phone number and website address may be modified on any forms included in this filing.
2. ERISA language will be included in employer accounts.
3. Officer signatures and titles are subject to updates as officer's names and/or titles change.

SECTION III: POLICY RATE SCHEDULE

1. The Policyholder, Policy Number, Policyholder Address, Billing Control Number, Policy Effective Date, Governing Jurisdiction and Policy Anniversary will vary by policyholder.
2. Eligible classes will vary based on policyholder definition. Definitions such as active employment, material and substantial duties, minimum hours per week and regular occupation will be added or deleted as appropriate. These definitions may include association or union terms, as appropriate.
3. The waiting period is the amount of time an applicant must spend in an eligible class before enrolling in the coverage. This is a policyholder choice and will range from **0-365 days**.
4. Rehire will be added or deleted as appropriate depending on the named insured's previous employment with the policyholder based on policyholder's plan.
5. Eligibility period is the period of time after the waiting period when an applicant may enroll and will vary based on policyholder choice and will be between **31-60 days**.
6. The two Policyholder Plan Choices for Life Benefit Amounts are multiple of annual earnings or incremental. For multiple of annual earnings plans, the policyholder may select up to five options ranging from **.25 up to 5x annual earnings** in **.25 increments** for the named insured. For incremental plans, the policyholder may select from a range of **\$10,000 - \$1,000,000** in **\$1,000 increments** for the named insured. This amount can also include buy-ups, if applicable.
7. The policyholder may choose from the following options: Life only, Life with Accidental Death & Dismemberment (AD&D) Base, Life with AD&D plus selected optional benefits. The AD&D Base plan includes Accidental Death, Accidental Dismemberment and the Seatbelt and Airbags Benefit. The optional benefits include: Paralysis Benefit, Coma Benefit, Burn Benefit, Common Carrier Benefit, Common Carrier with Motor Vehicle Benefit, Disappearance Benefit, Repatriation Benefit, Child Care Benefit, Career Adjustment for Spouse Benefit, Education for Dependent Children Benefit, Line of Duty Benefit, Felonious Assault Benefit, Human Immunodeficiency Virus (HIV) Benefit, and Hepatitis B or C. If the policyholder selects AD&D coverage, the optional benefits can be included in suites. The suite choices will be the

Catastrophic Suite, Travel Suite, Family Suite, Occupational Disease Suite or Malicious Intent Suite. If the policyholder selects AD&D coverage, the full amount of AD&D benefit will equal to the face amount of the Life Insurance Benefit. If the policyholder selects optional benefits, the named insured may choose whether or not to purchase them.

8. Spouse and dependent children coverage will be available based on the policyholder's plan. Spouse coverage can range from **\$5,000-\$1,000,000 in \$1,000 increments** and dependent children coverage can range from **\$1,000-\$20,000 in \$1,000 increments**.
9. The Accelerated Death Benefit will range from up to **75% of the face amount** to a maximum of **\$500,000**.
10. Cost of life insurance will vary based on plan selected. We will display the composite rates and/or age banded rates based on policyholder's plan. Spouse and dependent children coverage will be available based on the policyholder's plan.
11. Cost of AD&D insurance will vary based on plan selected. We will display the composite rates and/or age banded rates based on policyholder's plan. Spouse and dependent children coverage will be available based on the policyholder's plan.
12. The statement "the total AD&D amount for which a child is insured under this policy is subject to the maximum benefit available at certain ages", based on policyholder's plan.
13. The Rate Guarantee Period will be either: **one, two, three, four or five years**.
14. Divisions, subsidiaries or affiliated companies will be listed as appropriate.

SECTION V: PREMIUM PAYMENTS

1. Increases or Decreases in Premium provision – The notification to the policyholder of a premium change will vary based on the policyholder's plan, but will be **45 days, 60 days or 90 days**.
2. Grace Period (If Premiums Are Not Paid When Due) provision – The Grace Period will be either **31 days or 60 days**, based on the policyholder's plan.

CERTIFICATE, GTL1.0-C

SECTION I – FACE PAGE

1. Our company address, phone number and website address may be modified on any forms included in this filing.
2. ERISA language will be included in employer accounts.
3. Officer signatures and titles are subject to updates as officer's names and/or titles change.

SECTION II – CERTIFICATE GUIDE

1. Section XI: AD&D will be included or not, based on policyholder's plan.

2. The section numbers will change as sections are added or deleted, as appropriate.
3. Section XIII: Waiver of Premium will be included or not, based on policyholder's plan.
4. Section XIV: Portability will be included or not, based on policyholder's plan.

SECTION III – CERTIFICATE SCHEDULE

1. The Named Insured, Certificate Number, Issue Age, Coverage Effective Date, Monthly Premium as issue age, Policyholder, Group Policy Number, Billing Control Number, Policy Effective Date and Governing Jurisdiction will vary by policyholder and named insured.
2. The statement “for a multiple of salary plan, premiums are also subject to change based on any change in salary” will appear when the policyholder has selected a multiple of salary plan.
3. Life coverage for Named Insured will be **\$10,000-\$1,000,000 in \$1,000 increments** or multiple of salary based on policyholder's plan. For multiple of salary plans, the named insured chooses from the choices selected by the policyholder. In multiple of salary plans, the Life Coverage will display from .25 up to 5x annual earnings for the named insured based on the policyholder's plan.
4. Spouse coverage may be elected by the Named Insured from **\$5,000-\$1,000,000 in \$1,000 increments** if available based on policyholder's plan.
5. Dependent Child coverage may be elected by the Named Insured from **\$1,000-\$20,000 in \$1,000 increments** if available based on policyholder's plan.
6. Maximum Guarantee Issue Amount will vary for the Named Insured from **\$10,000-\$400,000**, Spouse from **\$5,000-\$100,000**, and Child will be **\$1,000-\$20,000**, if available based on policyholder's plan.
7. The statement “evidence of insurability is not required for amounts you had in force with the policyholder's prior carrier on the termination date of the prior carrier's plan” will be present in takeover situations.
8. The AD&D Insurance Benefit will be available or not, based on policyholder's plan.
9. The amount of AD&D coverage will match the amount of life coverage for the Named Insured, Spouse and Dependent Children, if applicable.
10. Spouse and Dependent Children will be included if coverage is elected. If coverage is not elected, references to spouse and dependent children will be removed.
11. The Paralysis Benefit, Coma Benefit, Burn Benefit, Common Carrier Benefit, Common Carrier with Motor Vehicle Benefit, Disappearance Benefit, Repatriation Benefit, Child Care Benefit, Career Adjustment for Spouse Benefit, Education for Dependent Children Benefit, Line of Duty Benefit, Felonious Assault Benefit, Human Immunodeficiency Virus (HIV) Benefit and Hepatitis B or C

Benefit will be included or not, based on policyholder's plan. If the policyholder selects AD&D coverage, the named insured will choose from the available options.

12. Waiver of Premium will be included or not, based on policyholder's plan.
13. If Waiver of Premium is selected, the Elimination Period will be a choice of **90 days, 120 days, 180 days, 270 days** or **360 days**.
14. If Waiver of Premium is selected, the Waiver of Premium Duration choices are to age 65, to age 70 or based on the Age Discrimination in Employment Act.
15. The statement "premium payments are required for you while you are disabled under this certificate" will appear when the policyholder has not selected a plan including Waiver of Premium.
16. The definition of Annual Earnings can vary based on policyholder's plan. See the attached document with all available definitions of annual earnings.
17. The statements "you pay 100% of the cost of your coverage," "the Policyholder pays the cost of your coverage," "you and the Policyholder share the cost of your coverage" will vary based on policyholder's plan. This applies to life coverage for the named insured, spouse and dependent children, including AD&D coverage, if applicable. The statements "for your spouse and dependent children" will be included when spouse and dependent children coverage is elected. In addition, "you pay 100% of the cost of the coverage," "the Policyholder pays the cost of the coverage" and "you and the Policyholder share the cost of the coverage" will be included when spouse or dependent children coverage is elected and will vary based on policyholder's plan.

SECTION V – ENROLLMENT AND COVERAGE EFFECTIVE DATES

1. Waiting Period provision – The terms "employed by the policyholder" and "employment with the policyholder" will be changed to indicate membership for qualified future associations or unions.
2. Continuation of Coverage provision – This provision will be included or not, if the policyholder is transferring from a prior carrier's plan.
3. Continuation of Coverage provision – AD&D will be included or not, if AD&D coverage was included in the prior carrier's plan.
4. Continuation of Coverage provision – Spouse or dependent children will be included if included on the prior carrier's plan.
5. When You Can Change Your Coverage provision – The statement "you may not increase coverage for your dependents" will not be present if spouse and dependent children coverage is not included. This will not be included if spouse and dependent children's coverage can be increased.
6. When Changes to Your Coverage Take Effect provision – The statement "if a claim is paid during the policy year based on the new coverage amount, and additional premium is due because of a salary

change, this additional premium will be deducted from any claim payment” will be included in multiple of salary plans.

7. When You Are Eligible for Dependent Coverage provision – This provision will be included or not, based on policyholder’s plan.
8. If Your Spouse or Dependent Child is Disabled provision – This provision will be included or not, based on policyholder’s plan.

SECTION VI – TERMINATION OF INSURANCE

1. When Your Coverage Ends provision – The statement “the date your class is no longer included for insurance” will be included if the policyholder’s plan includes multiple classes of eligible individuals.
2. When Your Coverage Ends provision – The statement “unless continued due to a temporary layoff or leave of absence or due to an injury or sickness, as described in ‘If You Stop Working After Your Coverage Begins’” provision will be included if the “If You Stop Working after Your Coverage Begins” provision is present. This is based on policyholder’s plan.
3. When Spouse or Dependent Child Coverage Ends provision – This provision will be included or not, based on policyholder’s plan.
4. If Your Dependent Child Becomes Disabled While Covered Under the Policy provision – This provision will be included or not, based on policyholder’s plan.
5. If You Stop Working after Your Coverage Begins provision – This provision will be included or not, based on policyholder’s plan.
6. Family and Medical Leave Act provision – This provision will be included in employer groups.

SECTION XI – ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFIT

1. This section will be included or not, based on policyholder’s plan.
2. The optional benefits include: Paralysis Benefit, Coma Benefit, Burn Benefit, Common Carrier Benefit, Common Carrier with Motor Vehicle Benefit, Disappearance Benefit, Repatriation Benefit, Child Care Benefit, Career Adjustment Benefit, Education for Dependent Children Benefit, Line of Duty Benefit, Felonious Assault Benefit, Human Immunodeficiency Virus (HIV) Benefit, and Hepatitis B or C and these provisions will be included or not, based on policyholder’s plan. If the policyholder selects optional benefits, the named insured may choose whether or not to purchase them.
3. Line of Duty Benefit provision – This benefit will be the lesser of **10%-50% of the full AD&D amount** or **\$10,000-\$50,000**.

4. Human Immunodeficiency Virus (HIV) Benefit provision and Hepatitis B or C Benefit provision – The statement “if you test positive for HIV and Hepatitis B or C as a result of the same occupational accident, only one benefit will be paid” will be included only if both benefits are included.
5. Losses Not Covered Under the AD&D Insurance Benefit – The occupational injury exclusion will include “sustained by your covered spouse, if applicable” if any of the following benefits are included: Line of Duty Benefit, Felonious Assault Benefit, HIV Benefit or Hepatitis B or C Benefit.
6. Losses Not Covered Under the AD&D Insurance Benefit – The travel or flight in any aircraft exclusion will be removed if any of the following benefits are included: Common Carrier Benefit, Common Carrier with Motor Vehicle Benefit, Disappearance Benefit or Repatriation Benefit.
7. Losses Not Covered Under the AD&D Insurance Benefit – The travel or flight in any vehicle exclusion will be removed if any of the following benefits are included: Common Carrier Benefit, Common Carrier with Motor Vehicle Benefit, Disappearance Benefit or Repatriation Benefit.
8. Losses Not Covered Under the AD&D Insurance Benefit – The investigational or experimental procedures exclusion will appear if AD&D benefits are included.

SECTION XII – WAIVER OF PREMIUM

1. This section will be included or not, based on policyholder’s plan.
2. When Waiver Begins provision – “less than 65 and” will not appear when the ADEA option is selected.
3. When Waiver Begins provision – The two definitions of disability are present in the certificate. One will be removed based on the policyholder’s plan.
4. When Waiver Begins provision – Either one year or two years will appear, based on the policyholder’s plan.
5. Proof of Loss - Waiver of Premium provision – “Your regular occupation and” will be included based on the policyholder’s definition of disability.

SECTION XIII – PORTABILITY

1. This section will be included with or without Evidence of Insurability based on policyholder’s plan.
2. Portable Insurance Amounts provision – AD&D will be included or not, based on policyholder’s plan.
3. Portable Insurance Amounts provision – The statement “the amount of ported life insurance must be equal to the amount of ported AD&D insurance” will be included based on policyholder’s plan.
4. Applying for Portable Coverage provision – The statement “portable coverage is subject to evidence of insurability” will be included or not, based on whether the policyholder’s plan included guaranteed portability.

5. Applying for Portable Coverage provision – The statement “you have an injury or sickness under the terms of this certificate which has a material effect on life expectancy” will be included or not, based on whether the policyholder’s plan included guaranteed portability.
6. Applying for Portable Coverage provision – The definitions of injury and sickness will be included or not, based on whether the policyholder’s plan includes guaranteed portability.
7. Applying for Portable Coverage provision – The statement “your surviving spouse has an injury or sickness under the terms of this certificate, which has a material effect on life expectancy” will be included or not, based on whether the policyholder’s plan includes guaranteed portability.
8. Applying for Portable Coverage provision – The statement “if we determine that because of an injury or sickness you, your covered spouse, or your dependent children were not eligible for portability at the time you, your covered spouse, or your dependent children elected portable coverage, you will need to complete a conversion application to qualify for a conversion policy” will be included or not, based on whether the policyholder’s plan included guaranteed portability.
9. Increases or Decreases in Portable Coverage provision – The statement “you may not increase coverage for your spouse and dependent children” will be included or not, based on policyholder’s plan.
10. Increases or Decreases in Portable Coverage provision – AD&D will be included or not, based on policyholder’s plan.
11. Grace Period (If Premiums Are Not Paid When Due) for Portable Coverage provision – The Grace Period will be either **31 days** or **60 days**, based on policyholder’s plan.
12. Premium Rate Changes for Portable Coverage provision – The notification to the policyholder of a premium change will vary based on policyholder’s plan, but will be **45 days**, **60 days** or **90 days**.

“Policyholder” may be changed “Employer” or “Association”. Additional language may be added to support the structure of the entity. Depending on the type of group, the term Employer or Policyholder may be interchangeable. The plans will be issued according to state eligibility group statutory requirements.

Statement of Variability for Underwriting forms: GTL - B - S - Master

MASTER APPLICATION, GTL-B-S-Master

ENROLLMENT INFORMATION

1. Eligible classes will vary based on policyholder definition regarding the number hours worked weekly.
2. The definition of eligible class may be defined as something other than active employment working a set number of hours weekly.
3. The number of eligible employees will vary based on employer size and class.
4. The waiting period is the amount of time an applicant must spend in an eligible class before enrolling in the coverage. This is a policyholder choice and will range from 0-365 days.
5. Eligibility period is the period of time after the waiting period when an applicant may enroll and will vary based on policyholder choice and will be between 31-60 days.

LIFE COVERAGE SECTION

Basic Term Life Insurance (Employer Paid)

1. The percentage of employer paid premium will vary based on policyholder choice and will be up to 100%.
2. For employee coverage amounts multiple of salary will vary based on policyholder choice in .25 increments to five times annual salary.
3. If the policyholder chooses a plan with Accidental Death & Dismemberment coverage (AD&D) the policyholder may choose up to one AD&D suite. Suites include catastrophic suite, family suite, malicious intent suite, occupational disease suite, travel suite or none.

Basic Term Life Insurance (Employer Paid) and Supplemental Term Life Insurance (Employee Paid)

1. The percentage of employer paid premium will vary based on policyholder choice and will be up to 100%.
2. For employee coverage amounts multiple of salary will vary based on policyholder choice in .25 increments to five times annual salary.
3. Supplemental coverage amounts will vary based on policyholder choice in .25 increments to five times annual salary. The policyholder may choose up to five increments.
4. Dependent children coverage amounts will vary between \$1,000 minimum up to \$20,000 maximum in \$1,000 increments.
5. If the policyholder chooses a basic term life plan with Accidental Death & Dismemberment coverage (AD&D) the policyholder may choose up to one AD&D suite. If the policyholder

chooses a supplement term life plan with AD&D they may choose up to two AD&D suites. The employee would then choose one of the suites offered. Suites include catastrophic suite, family suite, malicious intent suite, occupational disease suite, travel suite or none.

Custom Plans

1. The rate guarantee may vary based on plan design.
2. There may be other custom plan design features based on policyholder request.

GTL1.0-P-Amend – The amendment may vary according to the policyholder’s plan.

GTL1.0-C-Amend– The amendment may vary according to the policyholder’s plan.

Statement of Variability for Underwriting forms: GTL-V-Master

MASTER APPLICATION, GTL-V-Master

ENROLLMENT INFORMATION

1. Eligible classes will vary based on policyholder definition regarding the number hours worked weekly.
2. The definition of eligible class may be defined as something other than active employment working a set number of hours weekly.
3. The number of eligible employees will vary based on employer size and class.
4. The waiting period is the amount of time an applicant must spend in an eligible class before enrolling in the coverage. This is a policyholder choice and will range from 0-365 days.
5. Eligibility period is the period of time after the waiting period when an applicant may enroll and will vary based on policyholder choice and will be between 31-60 days.

LIFE COVERAGE SECTION

Voluntary Term Life Insurance (Employee Paid)

1. Voluntary Term Life Insurance coverage amounts will vary based on policyholder choice in .25 increments to five times annual salary. The policyholder may choose up to five increments.
2. Dependent children coverage amounts will vary between \$1,000 minimum up to \$20,000 maximum in \$1,000 increments.
3. If the policyholder chooses a plan with Accidental Death & Dismemberment coverage (AD&D) the policyholder may choose up to two AD&D suites. The employee would then choose one of the suites. Suites include catastrophic suite, family suite, malicious intent suite, occupational disease suite, travel suite or none.

Custom Plans

1. The rate guarantee may vary based on plan design.
2. There may be other custom plan design features based on policyholder request.

GTL1.0-P-Amend – The amendment may vary according to the policyholder's plan.

GTL1.0-C-Amend– The amendment may vary according to the policyholder's plan.

Annual Earnings Definitions:

1. Current Income Excluding Deferred Compensation

Annual earnings means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation from this Employer, or income received from sources other than this Employer.

2. Current Income and Commissions Excluding Deferred Compensation

Annual earnings means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, or flexible spending account. It includes income actually received from commissions just prior to your date of loss but not renewal commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than this Employer.

3. Current Income, Bonuses Excluding Deferred Compensation

Annual earnings means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from bonuses from the prior calendar year just prior to your date of loss but does not include commissions, overtime pay, any other extra compensation, or income received from sources other than this Employer.

4. Current Income, Commissions, and Bonuses Excluding Deferred Compensation

Annual earnings means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made from pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions and bonuses just prior to his/her date of disability but does not include renewal commissions, overtime pay, any other extra compensation, or income received from sources other than this Employer.

Bonuses will be averaged for the lesser of:

- a. The prior calendar year's 52 week period of your employment with this Employer just prior to the date of loss; or
- b. The period of actual employment with this Employer.

Commissions will be averaged for the lesser of:

- a. The 52 full calendar week period of your employment with this Employer just prior to the date of loss; or
- b. The period of actual employment with this Employer.

5. Prior W-2 Income Before Taxes and After Deferred Compensation

Annual earnings means your average income as figured:

- a. From the box on your W-2 form which reflects wages, tips and other compensation received from this Employer for the calendar year just prior to the date of loss; or

- b. For the period of your employment with this Employer if you did not receive a W-2 form prior to the date of loss.

Average income is your total income before taxes. It does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from car, housing or moving allowance, employee contributions to a qualified deferred compensation plan, or income received from sources other than this Employer.

6. Current Income Before Taxes and Deferred Compensation

Annual earnings means your gross annual income from this Employer in effect just prior to your date of loss. It includes your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other compensation, or income received from sources other than this Employer.

7. Current Income and Commissions Before Taxes and Deferred Compensation

Annual earnings means your gross weekly income from this Employer in effect just prior to your date of loss. It includes your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than this Employer.

Commissions will be averaged for the lesser of:

- a. The 52 full calendar week period of your employment with this Employer just prior to the date of loss; or
- b. The period of actual employment with this Employer.

8. Prior Year K-1 Calendar Year

Annual earnings means your average weekly income as an insured partner and is figured:

- a. From the line which shows “net earnings (loss) from self-employment” from schedule K-1 of your partner’s federal income tax return from this Employer for the calendar year just prior to the date of loss; or
- b. If you have not been a partner during the year for which the most recent partnership federal income tax return was filed, your average annual income will be figured for the period of actual employment that you have been a partner.

It does not include income received from sources other than this Employer.

9. Prior W-2 Income Before Taxes and After Deferred Compensation without Bonuses

Annual earnings means your average annual income as figured:

- a. From the income box on your W-2 form which reflects wages, tips and other compensation received from this Employer for the calendar year just prior to the date of loss; or

- b. For the period of employment with this Employer, if you did not receive a W-2 form prior to your date of loss.

Average income is your total income before taxes. It does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from bonuses, car, housing or moving allowance, policyholder contributions to a qualified deferred compensation plan, or income received from sources other than this Employer.

- 10. **Annual earnings** means your annual rate of earnings from this Employer in effect (immediately prior to the date of loss) (at the time of enrollment for coverage). Annual earnings includes all earnings before any reductions. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date total disability begins.