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**State:** Arkansas **Filing Company:** Axis Insurance Company  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.002 Short Term  
**Product Name:** Group Short Term Disability  
**Project Name/Number:** /

## Filing at a Glance

Company: Axis Insurance Company  
Product Name: Group Short Term Disability  
State: Arkansas  
TOI: H11G Group Health - Disability Income  
Sub-TOI: H11G.002 Short Term  
Filing Type: Form  
Date Submitted: 09/14/2012  
SERFF Tr Num: PLIS-128686510  
SERFF Status: Closed-Approved  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: GSTD-AR  
  
Implementation: On Approval  
Date Requested:  
Author(s): John Plisky  
Reviewer(s): Donna Lambert (primary)  
Disposition Date: 09/19/2012  
Disposition Status: Approved  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Axis Insurance Company  
**TOI/Sub-TOI:** H11G Group Health - Disability Income/H11G.002 Short Term  
**Product Name:** Group Short Term Disability  
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## General Information

Project Name: Status of Filing in Domicile: Not Filed  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments: AR-specific.  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Large  
 Group Market Type: Employer, Association, Discretionary, Explanation for Other Group Market Type: labor unions, PEOs, independent contractors  
 Trust, Other  
 Overall Rate Impact: Filing Status Changed: 09/19/2012  
 State Status Changed: 09/19/2012  
 Deemer Date: Created By: John Plisky  
 Submitted By: John Plisky Corresponding Filing Tracking Number:

Filing Description:  
 Please see attached cover letter.

## Company and Contact

### Filing Contact Information

John Plisky, Consultant j.plisky@verizon.net  
 Plisky Plisky & Co. LLC 732-223-0770 [Phone]  
 617 Union Ave., Bldg. 1-2 732-223-1776 [FAX]  
 Brielle, NJ 08730

### Filing Company Information

(This filing was made by a third party - pliskypliskyandcollc)  
 Axis Insurance Company CoCode: 37273 State of Domicile: Illinois  
 11680 Great Oaks Way, Suite 500 Group Code: 3416 Company Type:  
 Alpharetta, GA 30022 Group Name: State ID Number:  
 (888) 870-2947 ext. [Phone] FEIN Number: 39-1338397

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: 4 forms x \$50 each = \$200  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Axis Insurance Company	\$200.00	09/14/2012	62715077

State: Arkansas Filing Company: Axis Insurance Company  
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	09/19/2012	09/19/2012

**State:** Arkansas  
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## Disposition

Disposition Date: 09/19/2012

Implementation Date:

Status: Approved

Comment: ACA 23-86-106 defines eligible groups. This approval is subject to the company's compliance with the requirements of 23-86-106(2).

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Supporting Document	List of Forms	Approved	Yes
Supporting Document	Statement of Variable Language	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Form	Policy	Approved	Yes
Form	Certificate	Approved	Yes
Form	Master Application	Approved	Yes
Form	Amendment Form	Approved	Yes

State: Arkansas

Filing Company:

Axis Insurance Company

TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term

Product Name: Group Short Term Disability

Project Name/Number: /

## Form Schedule

### Lead Form Number: T-GSTD-001-0112-AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved 09/19/2012	T-GSTD-001-0112-AR	POL	Policy	Initial:		T-GSTD-001-0112-AR Policy.pdf
2	Approved 09/19/2012	T-GSTD-002-0112-AR	CER	Certificate	Initial:		T-GSTD-002-0112-AR Certificate.pdf
3	Approved 09/19/2012	T-GM-003-0112	AEF	Master Application	Initial:		T-GM-003-0112 Master App.pdf
4	Approved 09/19/2012	T-GM-005-0112	POLA	Amendment Form	Initial:		T-GM-005-0112 Amendment.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

[LOGO]1

## GROUP SHORT TERM DISABILITY INSURANCE POLICY 2

Underwritten by:  
AXIS INSURANCE COMPANY  
[11680 Great Oaks Way, Suite 500, Alpharetta, GA 30022]3  
A Stock Company  
(Herein called the Company)

The Company will pay the benefits of this Policy subject to its provisions. This page and the pages that follow are part of this Policy.

**Group Policy No.:** [AXIS-XXXXXXX]5

**Policyholder:** [ABC COMPANY] [ABC ASSOCIATION]4

### PREMIUM PAYMENTS

This Policy is issued in return for the payment by the Policyholder of required premiums. Premiums are payable at the home office of the Company or to its authorized agent. The first premium is due on the effective date of this Policy. Later premiums are due [monthly in advance on the first day of each month.]6 These dates are the premium due dates.

### EFFECTIVE DATE

This Policy will take effect on [January 1, 2013.] [This Policy replaces Group Policy No. AXIS-XXXXX, which was issued by the Company and took effect as of January 1, 2001.]7

### POLICY ANNIVERSARIES

Policy Anniversaries will be [January 1, 2014 and each subsequent January].8

### APPLICABLE LAW

This Policy is a legal contract between the Policyholder and the Company. This Policy is issued in and governed by the laws of [State].9

The President and Secretary of the Company witness this Policy.

[

[



Secretary

]10



President

]11

**GROUP SHORT TERM DISABILITY INSURANCE POLICY**  
**THIS IS LIMITED BENEFIT COVERAGE.**  
**[A PRE EXISTING CONDITION LIMITATION MAY APPLY.]**  
**PLEASE READ THIS POLICY CAREFULLY**  
[Non-Participating]

**POLICY INDEX**

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Premium Provisions ..... [4]

General Provisions ..... [7]

**INCORPORATION PROVISIONS**

1. From the effective date of the Policy, changes in the following items will be made a part of this Policy:
  - a. the name of the [Policyholder; Subscriber];
  - b. the premium rates;
  - c. amounts of insurance, eligibility, benefit descriptions, or any other provisions incorporated into the Policy.
2. Any change in item "1" above will be given on the Company's forms.
3. The effective date of incorporation of a provision or another change that affects the insurance of any person insured under this Policy will be the later of:
  - a. the effective date of this Policy;
  - b. the date of any amendment to this Policy that changes the Company's obligation to pay benefits under this Policy.
4. All of the benefits and provisions in an insured person's certificate of insurance issued under this Policy are made a part of this Policy.]

**PARTICIPATION REQUIREMENTS**

**[Minimum [Subscriber] Participation Requirements:**

[0-100] [%] of [all] eligible [Employees] [Members]]

**[PREMIUM [RATE] TABLE**

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

[\_\_\_\_\_ per \_\_\_\_\_, due and payable for the Policy Term]  
[\_\_\_\_\_ per \_\_\_\_\_, due and payable in annual installments with the first installment due as of the Policy Effective Date and subsequent installments due as of each anniversary date.]**1**

[The premium for the Policy Term is the greater of (1) \$XXX (the Minimum Premium) or (2) an amount calculated by multiplying the number of persons insured by a per-person rate of \$XXX (the Calculated Premium). The Minimum Premium is due and payable in advance of the Policy.]

[Effective Date. The Calculated Premium will be determined upon completion of an audit by the Company or its representative during the Policy Term. If the Calculated Premium is greater than the Minimum Premium, the difference between the Minimum Premium and the Calculated Premium is due and payable upon receipt of written notice by the Company to the Policyholder of the amount owed.]

[The Initial Premium Rate Guarantee [and any premium rate guarantee] applicable to renewal are subject to the *Cancellation* and *Premium Rate Change* sections of the *Administrative Provisions* of This Policy]**2**

[Mode of Premium Payment      [Single Premium; Quarterly; Semi-Annually; Annually]**3**

[Premium Due Date[s]           Policy Effective Date [and each Policy Anniversary thereafter]**4**

[Initial Premium                 [\$12,500]**5**

**[Contributions The cost of coverage is paid by the [Policyholder; Subscriber; Insured Person], [Minimum and deposit premiums are fully earned and non-refundable]6**

**[The Policyholder agrees to pay the required premium for these coverages.]7**

## **PREMIUM PROVISIONS**

### **[Grace Period**

A grace period of [31 to 180] days will be provided for the payment of any premium due after the first. During the Grace Period, the Policy shall continue in force, unless the [Policyholder, Subscriber] has given written notice of discontinuance in advance of the premium due date and in accordance with the terms of this Policy. If the required premium is not paid during the Grace Period, coverage will terminate on the last day of the Grace Period. The [Policyholder, Subscriber] will be liable for the payment of a pro rata premium for the time the Policy was in force during the Grace Period.]

### **Premiums**

Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Rate Table*, the plan and amounts of insurance in effect for [Insured Persons] and the premium mode selected, as shown in the *Schedule of Benefits*. [Optional, i.e.: If [Insured Persons'] coverage amounts are reduced due to age, premium will be based on the amounts of coverage in force on the day before the reduction took place.] The Company will provide notifications of premiums due or premium changes, by mail to the most current address in the Company files, to the Policyholder [and/or any affected Subscribers].

### **Premium Payment**

#### **[1. Policyholder**

The total premium paid by the Policyholder is the sum of premiums for all [Insured Persons] [Optional, i.e. Included only when contributory coverage is offered: including any amounts contributed toward the cost of the coverage by [Insured Persons]. The initial premium is due on the Policy Effective Date [and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits*.] unless the Policyholder and The Company agree to another mode of premium payment. Premiums are paid at the Company's home office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Policy Grace Period section.]

#### **[2. Subscriber**

The total premium paid by the Subscriber is the sum of premiums for all [Insured Persons] [Optional, i.e. Included only when contributory coverage is offered; including any amount contributed toward the cost of the coverage by [Insured Persons]. The initial premium is due on the Subscriber's effective date of participation under this Policy [and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits*] unless the Subscriber and the Company agree to another mode of premium payment. Premiums are paid at the Company's home office or to the Company's authorized agent.

If any premium is not paid when due, the Subscriber's participation under this Policy will be terminated as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.]

[Optional, i.e. Will not be included in non-renewable cases:]

### **[Premium Rate Changes**

We may change premium rates at the end of any Policy Term [or any Premium Rate Guarantee Period] with at least [31] days advance notice mailed to the last known address of the [Policyholder; Subscriber]. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term [or during any applicable Premium Rate Guarantee Period] if any one of the following occurs:

1. the terms of this Policy change;
2. the number of [Insured Persons] [or persons eligible for coverage] increases or decreases by more than [10%] since the later of the Policy Effective Date and the date of the last renewal of this Policy;]
3. coverage is reinstated following failure to pay premium during the Grace Period;]
4. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by [10%] or more the number of [eligible; insured] [Insured Persons];]
5. a change in [Insured Persons] [or persons eligible to be covered] which would, on a manual rate basis, require a change of [10%] or more in the premium rate;]
6. a change in any federal or state law or regulation is enacted; adopted or amended to the extent it affects the Company's benefit obligations under this Policy;]
7. the ratio of incurred claims to earned premiums since [the later of the Policy Effective Date and the last renewal date] exceeds [100%]; [the permissible loss ratio];]
8. [the Policyholder; Subscriber] fails to provide sufficient information, as required by The Company, to confirm adequacy of premiums and rates currently being paid;] or
9. any [facultative] reinsurance obtained by the Company in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by [10%] or more, or the Company retention increases by [10%] or more.]

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.]

**[Premium Audit**

The Company will have the right to audit books and records of the [Policyholder, Subscriber] at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.]

**[Reinstatement**

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the [Policyholder, Subscriber] satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than [60 days] prior to the date of reinstatement.]]

**[Cancellation**

*(Optional, depending on Policy Term)*

The Company or the [Policyholder; Subscriber] may cancel this Policy, after the first year [or Policy Term], [as of any Premium Due Date] by giving the other party [31; 45; 60 days] advance written [or authorized electronic] notice. Any premium rate guarantee will not affect the Company's [or the Policyholder's; Subscriber's] right to cancel this Policy.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*.

Cancellation does not affect a claim for which the claim is payable before the cancellation date.]

All Certificates under this Policy will terminate on the same date as the Policy.

## **GENERAL PROVISIONS**

### **Addition of New [Employees /Members]**

All [Employees/Members] added to the Eligible Classes in the *Schedule of Benefits* are eligible for insurance under this Group Policy.

### **Assignment**

[An [Insured Person] may not assign any of His rights, privileges or benefits under the Policy.] [An [Insured Person] may assign all of His rights, privileges and benefits under the Policy without the consent of His designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.]

### **Certificates**

Where required by law, the Company will provide a certificate of insurance for delivery to [the Insured Person]. Each certificate will set forth a statement as to the insurance coverage to which the [Insured Person] is entitled, to whom the insurance benefits are payable, and a statement as to any family member, Spouse or Dependent's coverage. If family members or Dependents are included in the coverage, the insurer need only issue one certificate to each family unit.

*(Included when the Insured Person pays any part of the premium)*

### **[[30 Day] Right to Examine Certificate**

If the [Insured Person] does not like the Certificate for any reason, it may be returned to the Company within [30] days after receipt. The Company will return any premium that has been paid. In that case, the Certificate will be void as if it had never been issued.]

### **Clerical Error**

A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, the Company will adjust the premium fairly.

### **Conformity with Statutes**

Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Entire Contract; Changes**

The Policy [, the master application] and any attached papers make up the entire contract between the [Policyholder; Subscriber] and the Company. [In the absence of fraud,] all statements made by the [Policyholder; Subscriber] or any [Insured Person] will be considered representations and not warranties. No written statement made by an [Insured Person] will be used in any contest unless a copy of the statement is furnished to the [Insured Person] or, in the event of the death or incapacity of the [Insured Person], to His beneficiary or personal representative.

No change in this Policy will be valid until approved by one of the Company executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

If an enrollment form for an [Insured Person] is required, it may also be made a part of this Policy at the Company's option.

### **Examination of the Policy**

This Policy will be available for inspection at the [Policyholder's; Subscriber's] office during regular business hours.

### **Incontestability**

The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium [, misrepresentation or fraud].

<b>Misstatement of Fact</b>	If the [Policyholder; Subscriber] has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.
<b>Noncompliance with Policy Requirements</b>	Any express or implied waiver by the Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Company to enforce any Policy provision will not be a waiver or amendment of that provision.
<b>Policy Changes</b>	No change in this Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to this Policy. The Company may agree with the [Policyholder; Subscriber] to modify a plan of benefits without the [Insured Person's] consent.
<b>Records</b>	The [Policyholder; Subscriber] or its authorized administrator will maintain the records of the [Insured Person's] insurance under this Policy. The Company will be permitted to examine the [Policyholder's; Subscriber's] records relating to the insurance under this Policy at any reasonable time. The [Policyholder; Subscriber] is acting as an agent of the [Insured Person] for transactions relating to this insurance. The actions of the [Policyholder; Subscriber] will not be considered the actions of the Company.
<b>[Reporting Requirements</b>	<p>The [Policyholder; Subscriber] or its authorized agent must report all of the following to the Company by the Premium Due Date:</p> <ol style="list-style-type: none"> <li>1. the names of all persons insured on the Policy Effective Date;</li> <li>2. the names of all persons who are insured after the Policy Effective Date;</li> <li>3. the names of those persons whose insurance has terminated; and</li> <li>4. additional information required by the Company.]</li> </ol> <p>[The Company, at the Company's sole discretion, may waive reporting of any information specified above.]</p>
<b>[Subscriber Participation Under This Policy</b>	An organization may elect to participate under this Policy by submitting signed Subscriber participation agreement to the [Policyholder; Subscriber]. No participation by an organization is in effect until approved by the Company.]
<b>Workers' Compensation Insurance</b>	This Policy is not in place of and does not affect any requirements for coverage under Worker's Compensation law.

## **CONSUMER INFORMATION NOTICE**

### **The Insurance Company may be contacted at:**

Axis Insurance Company  
[Admin. Office: 1 University Square Drive, Suite 200  
Princeton, NJ 08540  
1-800-123-4567]

### **The Insurance Agent may be contacted at:**

[Joseph Agent  
123 Main Street  
Anytown, AR 12345  
1-800-234-5678]

### **The State Insurance Department may be contacted at:**

Arkansas Insurance Department  
[1200 West Third Street  
Little Rock, AR 72201-1904  
1-800-282-9134 or (501) 371-2640]

[LOGO]

**GROUP SHORT TERM DISABILITY INSURANCE CERTIFICATE**

Underwritten by:  
AXIS INSURANCE COMPANY  
[11680 Great Oaks Way, Suite 500, Alpharetta, GA 30022]  
A Stock Company  
(Herein called the Company)

**CERTIFICATE OF INSURANCE**

AXIS Insurance Company (the Company) certifies that certain Eligible Persons are [Insured Persons] for the benefits described in this Certificate. This insurance is subject to the eligibility and effective date requirements described in the ELIGIBILITY section of this Certificate.

**[DATE YOUR INSURANCE TAKES EFFECT**

[Your insurance will take effect on the date shown on this Certificate. [You must be in Active Service and in an Eligible Class on this date. [If You are not in Active Service, Your insurance will take effect on the day You resume such work.]]

[The date insurance is to take effect might not be a scheduled workday. If so, You will be considered in Active Service on such date if You were in Active Service [on Your last scheduled workday]. [You are considered in Active Service:

- during Your normal vacation time provided by Your Employer;
- during jury duty;
- on any holiday, or day of the weekend; or
- on any day of an excused leave approved by Your Employer.]]

**IMPORTANT NOTICE**

This Certificate is a summary of the group policy (the "Policy") provisions that affects Your insurance. It is merely evidence of the insurance provided by such Policy for \_\_\_\_\_ the Policyholder.

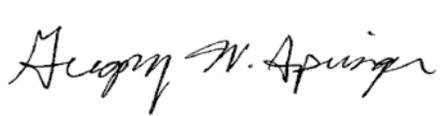
The Policy is a contract between the Company and the Policyholder. It may be changed or ended without notice to or consent of any [Insured Person]. [The benefits described in this Certificate are provided by Policy number [ ].] [This Certificate replaces any certificate previously issued by the Company to You under the Policy.] [This Certificate replaces any certificate previously issued by another AXIS Insurance Company to You under that AXIS company's group policy.] [The Company is providing this electronic version of the Certificate at the request of the Policyholder. The Policyholder maintains the Policy, which includes a copy of the Certificate. The Policy is available for You to review and copy. If there is any conflict between the information in this electronic version of the Certificate and the Policy, the Policy will control in all respects.]

**[RIGHT TO EXAMINE CERTIFICATE.** The Certificate issued to each [Insured Person] can be returned for any reason within [10; 30; 31] days after it is received by the [Insured Person]. The Certificate should be returned by mail or in person to the Company. Any premium paid will be refunded and the Certificate will be treated as if it were never issued.]

The President and Secretary of AXIS Insurance Company witness this Certificate.



President



Secretary

**THIS IS LIMITED BENEFIT COVERAGE.  
[A PRE EXISTING CONDITION LIMITATION MAY APPLY.]  
PLEASE READ THIS CERTIFICATE CAREFULLY.  
[Non-Participating]**

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Description of Benefits .....	[X]
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## SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, PLEASE READ ALL OF THE CERTIFICATE PROVISIONS CAREFULLY.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by the Policy. Please read the Description of Benefits sections for full details.

<b>[ELIGIBLE CLASSES]</b>	[Class 1: All [Employees; Members] of the Policyholder who are in Active Service.]
<b>Type of Coverage</b>	[Insured Person]
<b>Coverage Effective Date</b>	[January 1, 2013]
<b>[Policy Effective Date]</b>	[January 1, 2013]
<b>[Rewrite Effective Date]</b>	[January 1, 2013]
<b>Policy Anniversary Date</b>	[January 1, 2014 ]
<b>[Open [Annual][Policyholder Scheduled Enrollment ] Period]</b>	[November 1] of each succeeding year]
<b>[Waiting Period]</b>	[0-90] Days] [per Class]]
<b>[Minimum hours of work per week]</b>	[0-40] [per Class]]
<b>[Open [Annual] Enrollment Effective Date]</b>	January 1 following the subsequent Open Enrollment Period]
<b>[Minimum [Subscriber] Participation Requirements]</b>	[[0%-100%] of eligible [Employees] Members]]
<b>[Premium]</b>	[\$XX.XX]]
<b>[Premium Mode]</b>	[Monthly]]
<b>[Premium Due Date]</b>	[January 1, 2013]]
<i>[(Information required should the Company take over coverage mid-Plan Year or Policy Year)]</i> <b>[Plan Year]</b> <b>[Coverage Termination Date]</b>	

[If an [Insured Person] is eligible under one Eligible Class and later becomes eligible under a different Eligible Class, changes in His insurance due to the Class change will be effective on the date of the change in Class.]

**[Gross Disability Benefit:** the lesser of [25%-100%] of the [Insured Person's] weekly Basic Earnings rounded to the nearest dollar or the Maximum Disability Benefit]

**[Maximum Disability Benefit:** [Option 1: [\$100-\$2,000] per week]  
[Option 2: [\$100-\$2,000] per week]

**[Minimum Disability Benefit:** [\$25-\$100] per week]

**Maximum Benefit Period:**

For Accidents: The date the [7<sup>th</sup> - 52<sup>nd</sup>] Weekly Benefit is payable  
 For Sickness: The date the [7<sup>th</sup> - 52<sup>nd</sup>] Weekly Benefit is payable  
 [For Inpatient Hospital Add classes] The date the [7<sup>th</sup> - 52<sup>nd</sup>] Weekly Benefit is payable]

**[Disability Benefit Calculation** the benefit payable to the [Insured Person] for any week the [Insured Person] is Disabled is the Gross Disability Benefit minus Other Income Benefits.]

**[Waiver of Premium]** [Applies, please see the Waiver of Premium section in the benefits section of this Certificate]

**Initial Premium Rates:** [Monthly: Weekly: Bi-Weekly]  
[100%] [Policyholder] [Insured Person] paid

**[Insured Person] Only:** Option 1: [\$100- \$1,000] per week  
\$[XX.XX] Ages 17 – 49  
\$[XX.XX] Ages 50 - 69

Option 2: [\$100-\$1,000] per week  
\$[XX.XX] Ages 17 – 49  
\$[XX.XX] Ages 50 - 69

**[Benefit Waiting Period:** [The later of any accumulated sick leave or the time period shown below]:

[For Accidents:	[0-30] consecutive days]
[For Sickness:	[0-30] consecutive days]
[For Inpatient Hospital:	[0-30] consecutive days]

[The Benefit Waiting Period will end on the date the [Insured Person] is admitted as an Inpatient in a Hospital if that date is before the end of the time period specified.]]

**[Pre-Existing Condition Limitation** [None][6, 12, 24] months after the Coverage Effective Date under this [Policy][Certificate]]

**[[Return to Work Incentive]**

An [Insured Person] may work or profit while Disabled. In any week in which the [Insured Person] works and a Disability Benefit is payable, the Return to Work Incentive Benefit Calculation applies.

During any week the [Insured Person] has Disability Earnings, His benefit will be calculated as follows:

1. add the [Insured Person's] Gross Disability Benefit and Disability Earnings;
2. compare the sum from 1. to the [Insured Person's] Basic Earnings;
3. if the sum from 1. Exceeds 100% of the [Insured Person's] Basic Earnings, then subtract the Basic Earnings from the sum in 1;
4. the [Insured Person's] Gross Disability Benefit will be reduced by the difference from 3. as well as by Other Income Benefits;
5. if the sum from 1. does not exceed 100% of the Employees Basic Earnings, the Employee's Gross Disability Benefit will be reduced by the Other Income Benefits.

[No Disability Benefit will be paid, and insurance will end if the Company determines the [Insured Person] is able to work under a modified work arrangement and refuses to do so without Good Cause.]]

## **DEFINITIONS**

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

*Note: Definitions will vary to ranges displayed within brackets and will be included or omitted depending on coverages selected.*

- [Accident or Accidental]** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the [Insured Person] is covered under this Policy.]
- [Active Service Actively at Work]** [means the [Insured Person] will be considered in Active Service with His Employer on any day that is either of the following:
1. one of the [Employer's] scheduled work days on which the [Employee] is performing His regular duties on a [Full-Time basis] [part-time basis], either at one of the [Employer's] usual places of business or at some other location to which the [Employer's] business requires the [Employee] to travel; or
  2. a scheduled holiday, vacation day or period of [Employer]-approved paid leave of absence, other than sick leave, only if the [Employee] was in Active Service on the preceding scheduled workday.]
- (Include when eligibility is not based on employment)*
- [The [Member] [Insured Person] is considered in Active Service if He is none of the following:
1. an Inpatient in a Hospital or receiving outpatient care for chemotherapy or radiation therapy;
  2. confined at home under the care of a Physician for Sickness or injury; or
  3. Disabled.]]
- [Age]** means an [Insured Person's] age for purposes of [initial] premium calculations. It is His Age attained on the later of the first day of the Policy Term and the Coverage Effective Date for Him under this Policy.]
- [Annual Re-Enrollment]** means a period of time set by the Policyholder and the Company during which [Insured Person] may apply, in writing, for coverage under the Policy, or change coverage if He is currently enrolled.]
- [Any Occupation]** means that an individual is unable to perform the essential duties of any occupation for which He is reasonably qualified by training, education or experience.]
- [Appropriate Care]** means the determination of an accurate and medically supported diagnosis of the [Insured Person's] Disability, or ongoing medical treatment and care of the [Insured Person's] Disability by a Physician that conforms to generally accept medical standards, including frequency of treatment and care.]
- [Basic Earnings]** means an [Insured Person's] earnings as figured from the W-2 form (from the box that reflects wages, tips and other compensation excluding bonuses for federal income tax purposes) received from the [Employer] for the calendar year just prior to the date Disability begins. If the [Insured Person] was not employed by the [Employer] for the full year or no W-2 was received; it means an [Insured Person's] average [monthly

earnings as reported by the Employer for the months employed] [weekly earnings over the last [3] month or, if the [Insured Person] has not been employed for the last [3] months, the average earnings for the time period employed].]

[Basic Earnings includes tips received by the Insured Person.]

Basic Earnings are determined initially on the date an [Insured Person] applies for coverage. A change in the amount of Basic Earnings is effective on the Policy Anniversary Date following the change, if the [Employer] gives the Company written notice of the change and the required premium is paid.

An increase in an [Insured Person's] Basic Earnings will not be effective during a period of continuous Disability.]

## **[Basic Earnings**

means your annual compensation from your *Employer*.]

Basic Earnings include:

- [your average monthly compensation from your *Employer* during the *Employer's* prior tax year if you were a Partner, Professional Corporation (P.C.) Partner, Owner-[Insured Person], Sole Proprietor and/or S-Corporation Shareholder];
- [the average annual compensation received by your professional corporation from the *Employer* during the *Employer's* prior tax year. The *Company* will calculate annual earnings by adding the following items as reported on the applicable Schedule K-1, Schedule C, Form W-2, or S-Corporation federal income tax return, or by the number of months that you were a Partner, Professional Corporation (P.C.) Partner, Owner-[Insured Person], Sole Proprietor and/or S-Corporation Shareholder if less than 12 months. This includes:
  - your ordinary income from trade or business activities;
  - your guaranteed payments if you were a Partner;
  - your net profit from the business;
  - your compensation (as an officer), salary or wages, if you were a S-Corporation Shareholder]
- [your average annual rate of compensation from your Employer including:
  - average annual salary
  - regular hourly wages (but not for more than 40 hours a week)
  - commissions averaged over the preceding [12-36] months or the period of your employment if less than [12-36] months]
- [shift differential pay]
- [contributions you make through a salary reduction agreement with the Employer to:
  - an Internal Revenue Code (IRC) 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement;
  - an executive nonqualified deferral compensation arrangement]
- [amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC section 125 plan.]

[Basic Earnings does not include:

- tips
- bonuses
- overtime pay
- extra compensation
- your Employer's contributions on your behalf to any deferred compensation plan or pension plan
- income you earn as a private contractor on IRS Form 1099
- stock options]
- [commissions]

[If the [Insured Person] is a commissioned sales person, Basic Earnings will be any salary or wages and commissions received from the Employer. This will be based on the Statement of Wages Earned and Taxes Withheld (Form W-2) for the fiscal year ending immediately prior to the date of the [Insured Person's] death.] [Commissions will be the average of commissions paid for the past [2-4] years].

[Basic Earnings are determined initially on the date an [Insured Person] applies for coverage. A change in the amount of Basic Earnings is effective on the Policy Anniversary Date following the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid.

Any increase in an [Insured Person]'s Basic Earnings will not be effective during a period of continuous Disability.]]

**[Benefit Waiting Period**

means a period of continuous Disability which must be satisfied before the [Insured Person's] Disability Benefits may be payable. The Benefit Waiting Period is shown in the *Schedule of Benefits*.

The Benefit Waiting Period will be reduced to the extent the [Insured Person] was continuously insured under the corresponding benefit section of the Prior Plan.]

**[Company**

means AXIS Insurance Company.]

**[Complication(s) of Pregnancy**

mean(s) conditions which require Hospital stay before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are acute nephritis or nephrosis; or preeclampsia; or eclampsia; puerperal infection; or Rh factor problems; or [severe loss of blood requiring transfusion; or cardiac decomposition or [missed abortion]]; or [similar condition as severe as these above; non elective cesarean section; or termination of an ectopic pregnancy; and spontaneous termination when live birth is not possible. (This does not include voluntary or elective abortion).

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non elective. A cesarean section will be considered non elective if the fetus or the mother is determined to be in distress and is in immediate danger of death, Sickness or injury if the cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non elective if vaginal delivery is medically inappropriate, or vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or injury to child or mother.

Not included: (a) false labor, occasional spotting or Physician prescribed rest during the period of pregnancy; (b) morning sickness; [ (c) [hyper

emesis gravid arum] [and [pre eclampsia]]; and [(d)] similar conditions not medically distinct from a difficult pregnancy.]

<b>[Contributory Plan]</b>	means a plan for which the [Insured Person] pays a portion of the premium.]
<b>[[Core] [Basic Plan]</b>	means the noncontributory plan of benefits provided under this Policy.]
<b>[Coverage Effective Date]</b>	means the date shown on the <i>Schedule of Benefits</i> .]
<b>A. [Disabled/Disability]</b>	<p>an [Insured Person] is Disabled if, because of Injury or Sickness, the [Insured Person]:</p> <ol style="list-style-type: none"><li>1. [is unable to perform all the Material and Substantial Duties of His Regular Occupation;] [and]</li><li>2. [is unable to perform duties in Any Occupation].]</li></ol>
<b>B. [Disabled/Disability]</b>	<p>An [Insured Person] is Disabled if:</p> <ol style="list-style-type: none"><li>[1. because of Injury or Sickness, He is unable to perform the Material and Substantial Duties of His Regular Occupation;]</li><li>[2. solely due to Injury or Sickness, He unable to earn more than [60%-80%] of His Basic Earnings] [or]</li><li>[3. is unable to perform any work or Any Occupation.]</li></ol> <p>[Pregnancy is covered as a Disability only if the [Insured Person] has been insured without a break for 9 months.]]</p> <p>[Benefits are limited to a maximum of [6] weeks for any one pregnancy without Complications of Pregnancy and there is no Benefit Waiting Period. Complications of Pregnancy are covered the same as any other Sickness.]</p> <p>All Disabilities must commence while the Policy is in force.]</p>
<b>[Disability Earnings]</b>	Any wage or salary for any work performed for any employer during the [Insured Person's] Disability, including commission, bonus, overtime pay or other extra compensation.]
<b>[Eligible Class]</b>	means the classes listed in the <i>Schedule of Benefits</i> .]
<b>[Eligibility Waiting Period]</b>	means the period of time of continuous employment that the [Insured Person] must satisfy before coverage under this Certificate is effective.]
<b>[Employee]</b>	means, for eligibility purposes, a person working for the [Employer] who is in an Eligible Class as shown in the <i>Schedule of Benefits</i> . [The term does not include employees who work less than [10-45] hours per week for the [Employer].] [The term may include retired employees of the Employer.]]
<b>[Employer]</b>	means the [Policyholder] [Subscriber] and any affiliates, subsidiaries or divisions shown in the [Master Application] [Master Policy] [Subscriber Application] covered under this Policy on its effective date, or a later date agreed to by the Company.]
<b>[Good Cause]</b>	means a medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Company.]

<b>He, His, Him, You, Yours</b>	refers to any individual, male or female.
<b>[Hospital Confined/ Hospital Stay</b>	means an Inpatient overnight Hospital Stay. Separate Hospital Stays due to the same Covered Injury or Covered Sickness will be treated as one Hospital Stay unless separated by at least [30-180] days.]
<b>[Hospital</b>	<p>an institution that meets all of the following:</p> <ol style="list-style-type: none"> <li>1. it is licensed as a Hospital pursuant to applicable law;</li> <li>2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;</li> <li>3. it is managed under the supervision of a staff of medical doctors;</li> <li>4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);</li> <li>5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and</li> <li>6. it charges for its services.</li> </ol> <p>[Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an inpatient shall be waived.]</p> <p>[The term Hospital does not include a clinic, facility, or unit of a Hospital for:</p> <ol style="list-style-type: none"> <li>1. rehabilitation, convalescent, custodial, educational or nursing care;</li> <li>2. the aged, drug addicts or alcoholics; or</li> <li>3. [a Veterans' Administration Hospital or Federal Government Hospital unless the [Insured Person] incurs an expense.]]] </li></ol>
<b>[Immediate Family Member</b>	means a person who is related to the [Insured Person] in any of the following ways: Spouse; brother-in-law; sister-in-law; daughter-in-law; mother-in-law; father-in-law; parent; siblings; (includes stepbrother or stepsister); grandparents or child (includes legally adopted or stepchild).]
<b>[Injury</b>	means any Accidental loss or bodily harm which results directly and independently of all other causes from an Accident.]
<b>[Inpatient</b>	means confined overnight as a registered bed patient in a Hospital or other medical facility where at least one day's room and board is charged. The confinement must be on the advice of a Physician.]
<b>[Insured Person</b>	means a person in an Eligible Class, as defined in the <i>Schedule of Benefits</i> , for whom required premium has been paid when due and for whom coverage under this Policy remains in force. ]
<b>[Material and Substantial Duties</b>	means duties that are normally required for the performance of your regular occupation; and cannot be omitted or modified.]
<b>[Nurse</b>	<p>means a licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:</p> <ol style="list-style-type: none"> <li>1. the [Insured Person];</li> <li>2. an Immediate Family Member of either the [Insured Person] or the [Insured Person's] Spouse; or</li> <li>3. a member of the same household.]</li> </ol>
<b>[Other Income Benefits</b>	<p>means any amounts received or assumed to be received by the [Insured Person] under:</p> <ul style="list-style-type: none"> <li>•the Railroad Retirement Act;</li> </ul>

- any local, state, provincial or federal government disability or retirement plan or lay payable for Injury or Sickness provided as a result of employment with the Employer;
- any sick leave or salary continuation plan of the Employer;
- any work loss provision in mandatory “No-Fault” auto insurance;
- any workers’ compensation, occupational disease, unemployment compensation law or similar state or federal lay payable for Injury or Sickness arising out of work with the Employer; including all permanent and temporary disability benefits, whether or no liability is admitted;
- any Social Security disability or retirement benefits the [Insured Person] or any third party receives or is assumed to receive on His own behalf for His dependents; or which His dependents receive or are assumed to receive because of His entitlement to such benefits;
- any Retirement Plan benefits funded by the Employer;
- any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Company will pay for its Pro Rata Share of the total claim;
- any amounts paid because of loss of earning or earnings capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.]

**[Physician**

means a licensed health care provider [and/or Licensed Therapist] practicing [in the United States] within the scope of His license and rendering care and treatment to the [Insured Person] that is appropriate for the condition and locality, and who is not:

1. the [Insured Person];
2. an Immediate Family Member of either the [Insured Person] or the [Insured Person's] Spouse;
3. member of the same household;
4. a person employed or retained by the [ Policyholder][Subscriber];  
or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.]]

**[Plan Year**

means the time period defined in the *Schedule of Benefits*. The initial Plan Year may be less than 1 year (12 months). Subsequent Plan Years will be a full 12 month time period.]

**[Policy Effective Date**

means the date the Policy takes effect for the Policyholder.]

**[Policyholder**

means the entity, named on the Policy’s face page, to which the Company issues the Policy.]

**[Pre-Existing Condition**

means a disease or physical condition for which medical advice or treatment was received by the [Insured Person] during the [6, 12] months prior to the [Insured Person’s] Coverage Effective Date under this [Certificate].]

**[Prior Plan**

means a group insurance policy issued to the [Policyholder] [Employer] [Subscriber] and in force immediately prior to the Policy Effective Date, and which provided similar benefits to this Policy.]

**[Pro Rata Share**

means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.]

**[Regular Occupation**

means the occupation that the [Insured Person] routinely performs when your Disability begins. The Company will look at the [Insured Person’s]

occupation as it is normally performed in the local economy, instead of how the work tasks are performed for a specific employer or at a specific location. ]

**[Rehabilitation Plan**

means a written plan designed to enable the [Insured Person] to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.]

**[Retirement Plan**

means any defined benefit or defined contribution plan sponsored or funded by the [Employer]. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or saving plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift stick option or stock bonus plan, individual retirement account or 401(k) plan.]

**[Schedule of Benefits**

means the *Schedule of Benefits* in this Certificate.]

**[Sickness**

means disease or illness, including related conditions and recurrent symptoms, which begin after the effective date of a [Insured Person's] coverage [and while coverage is in force under this Policy.] [Sickness also includes pregnancy, if the [Insured Person] has been insured under this Policy for a continuous 9 month period, [and Complications of Pregnancy].]

**[Subscriber**

means any participating [organization, etc.] that [is affiliated with the Policyholder and] subscribes to the insurance plan provided by this Policy.]

**[Waiting Period**

means the continuous period of time shown in the Schedule OF Benefit that you must be in Active Service in an eligible class before you are eligible for coverage.]

**We, Us, Our**

means AXIS Insurance Company and its duly authorized agents.

**You, Your**

means the person to whom this Certificate is issued.

## **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS**

### **[Policy Effective Date**

The Company agrees to provide the benefits described in this Certificate in consideration of the [Policyholder's] application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown in the *Schedule of Benefits* [as long as the Minimum Participation Requirement shown in the *Schedule of Benefits* has been satisfied].]

### **[Subscriber Effective Date**

The Company agrees to provide the benefits described in this Certificate in consideration of the Subscriber's application, subscription agreement and payment of the initial premium when due. Insurance coverage for the Subscriber becomes effective on the date of Subscriber's Participation [as long as the Minimum Participation Requirement shown in the *Schedule of Benefits* has been satisfied].]

### **Eligibility**

A [Insured Person] becomes eligible for insurance under this Certificate on the date He meets all of the requirements of one of the Eligible Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is an [Insured Person] under the Core Plan].

#### **[If Non-Contributory]**

[No enrollment is required if a person is not required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. [the first day of the month following] the date the person becomes a member of an Eligible Class after the Eligibility Waiting Period has been met;
3. the date for which the first premium for the person's coverage is paid; and
4. the Coverage Effective Date shown in the *Schedule of Benefits*.]

#### **[If Contributory]**

[A person is required to enroll for coverage for which He is required to contribute towards the cost of coverage. Such person's coverage will become effective on the latest of the following dates:

1. [the first day of the month following] the date the person's enrollment form is received by the Company[, if such date is within [31-90] days of the date He becomes a member of an Eligible Class];
2. the date for which the first premium for the person's coverage is paid;
3. the Coverage Effective Date shown in the *Schedule of Benefits*, provided premium for such person is paid; and
4. the Policy Effective Date.]

## **[DEFERRED EFFECTIVE DATE**

### **[Active Service**

The effective date of insurance will be deferred for any [Insured Person] who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date the person returns to Active Service or the date coverage would otherwise have become effective.]

### **[Late Enrollment**

If application for insurance is not made within [30-90] days of the date a person is first eligible for coverage [or a Life Status Change] [or during an Annual Re-Enrollment], the applicant will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of the date the Company approves the enrollment form and receives required premium, and the [date coverage would otherwise have become effective] [first of the month following the Company's approval].]

### **[Replacement Coverage**

[A [Insured Person] who was covered under a Prior Plan and who is not in Active Service on the Policy Effective Date [or the Subscriber's participation date] as shown in the *Schedule of Benefits* of this Certificate will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under this Certificate.

If the amount of coverage otherwise provided by this Certificate is greater than the amount provided under the Prior Plan, the greater amount will become effective on the [first day of the month on or after, or first day of the [Calendar] [Plan] Year on or after or date] the Insured Person], returns to Active Service.]

*Include this paragraph if contributions are required toward the cost of coverage:*

[If a [Insured Person] is required to contribute to the cost of any portion of His insurance and is not in Active Service on the effective date of [the Subscriber's participation under] the Policy, coverage will terminate [31] days after the [Insured Person] returns to Active Service unless He submits an enrollment form and the required initial premium. If the [Insured Person] selects the amount of benefit for which He is required to pay premium for Himself, the amount in effect under this provision will be the lesser of the amount provided under the Prior Plan and the smallest amount He may select under the Policy.]

#### **[Annual Re-Enrollment**

[A [Insured Person] currently covered under [the voluntary portion of] the Policy, and a person who is eligible but has not previously enrolled, may increase or become an [Insured Person] for coverage under this Certificate during an Annual Re-enrollment Period as agreed to by the Company and the [Policyholder]. Coverage elected during an Annual Re-Enrollment Period will become effective [, subject to the Active Service section of the Deferred Effective Date provision,] on [the Policy Anniversary following, or first day of the month following] the date the Company receives a request and any required premium payment.]

#### **[Life Status Change**

A Life Status Change is an event that the [Policyholder] determines qualifies a [Insured Person] to [elect or] increase Benefits provided under this Certificate . [Any change in benefit elections must be made within [31] days of a Life Status Change.]

[Life Status Changes that qualify a [Insured Person] to [elect or] increase His benefits under the Policy include:

- [1. marriage;]
- [2. loss of a Spouse, whether by death, divorce, annulment or legal separation;]
- [3. birth or adoption of a child, or acquiring a child through marriage;] [and]
- [4. an increase in cost or a significant reduction or loss of group benefits provided by a Spouse's Plan].]

[Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the [first of the month following the Life Status Change] [first day of the month following the] date the [Insured Person] applies and agrees to make required contributions.]

[The [Policyholder] should seek advice of its tax advisors if [Insured Persons] may contribute to the cost of any insurance provided by this Certificate with earnings not subject to Federal Income Tax. The Company cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.]]

*Include when policy is issued to an employer/employee group:*

#### **[Effective Date of Changes**

Any increase or decrease in the amount of insurance for the [Insured Person] resulting from a change in benefits provided by the Policy or a change in the [Insured Person's] covered class will take effect on the date of such change.

[Increases will take effect subject to any Active Service requirement.]]

## **DATE [EMPLOYEE] INSURANCE ENDS**

### **[Insured Person's] Termination Date;**

A [Insured Person's] coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the Grace Period provision in the Certificate);
2. [at the end of the month following] the date the [Insured Person] ceases to be a member of an Eligible Class;
3. the date the Policy terminates;
4. the date of the [Insured Person's] [60th-100th] birthday;
5. [the last day of the month in which the [Insured Person] reaches His Lifetime Certificate Maximum;]
6. [the last day of the month in which the [Insured Person] fails to pay when due any Contribution;]
7. the date the [Insured Person] notifies the Company in writing to discontinue His coverage;[or]
8. the date the [Insured Person] employer ceases to be a participating Employer.]]

### **[Reinstatement of Insurance**

If insurance ends because the [Insured Person] ceases to be eligible for coverage as defined in this Certificate, coverage may be reinstated and no additional waiting period will apply if, within 6 months after the date the insurance ends, the [Insured Person] becomes a member of an Eligible Class.]

### **[Exceptions to Termination of Insurance**

If the [Insured Person] terminates Active Service and if premium payments for His coverage are made when due, He may be considered to be in Active Service, subject to the conditions set forth below:

1. If the [Insured Person] terminates Active Service due to temporary lay-off or leave of absence, coverage may be continued until the earliest of the following dates:
  - a. the date the Policyholder ceases to pay the [Insured Person's] premiums, or otherwise terminates the insurance; or
  - b. [3 months from] the date the [Insured Person] ceases to be in Active Service; or
  - c. the date the Policy terminates.]
2. If the [Insured Person] terminates Active Service due to injury or Sickness, coverage under the Policy may be continued in accordance with the Continuation of Insurance provision.] [However, if the [Insured Person] is not eligible for continuance under the Continuation of Insurance provision and is no longer in Active Service due to injury or Sickness, then the longest they can be covered is for [12] months unless age [65] or older.]
3. If the [Insured Person] terminates Active Service due to retirement, coverage under the Policy may be continued provided:
  - a. the [Policyholder] has elected retiree coverage; and
  - b. the [Insured Person] meets the [Policyholder's] definition of retired.]]

### **[Continuation for [Layoff, Leave of Absence or Family Medical Leave]**

Insurance for a [Insured Person] may be continued until the earliest of the following dates if: (a) an [Insured Person] is on [a temporary layoff] [an Employer-approved leave of absence][or an Employer-approved family medical leave]; and (b) required premium contributions are paid when due.

1. for a layoff, [[6 months] after] the end of the month in which the layoff begins;]
2. for an Employer-approved leave of absence: [[6 months after] the end of the month after the month in which the leave begins;] [and]
3. for an Employer-approved family medical leave [12-52] weeks in a consecutive 12-month period.]]

[Such continuation will [run concurrently with] [precede] a continuation during any other leave.]

### **[Continuation for Military Service**

If a [Insured Person] begins a leave of absence to serve in the armed forces, insurance for the [Insured Person] will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months; and
2. the day the [Insured Person] fails to return to work as outlined in the Uniformed Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived;] [and]
3. the [Insured Person] will be given credit for the time He was covered under this Certificate prior to the leave.

If a [Insured Person] does not continue coverage for during such leave and returns to work:

1. the [Insured Person] will be covered on the date the [Insured Person] returns to work from the leave. The [Insured Person] must return to work as outlined in the Uniformed Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during the [Insured Person's] leave.]

**[Continuation of Insurance**

If the [Insured Person's] Active Service ends for any reason, other than termination of employment for gross misconduct, insurance for a [Insured Person] will continue, if the required premium is paid, until the earliest of the following dates:

1. the 18-month period following the [Insured Person's] last day of full-time work; or
2. the date the Policy terminates.

Any change in benefits that occurs during a period of continuation will apply on the date the [Insured Person] returns to Active Service.]

## **ADMINISTRATIVE PROVISIONS**

### **[Cancellation**

The Company or the [Policyholder] may cancel this Policy, [after the [first year] [or] [Policy Term] [as of any Premium Due Date] by giving the other party [31; 45; 60 days] advance written [or authorized electronic] notice. Any premium rate guarantee will not affect the Company's or the [Policyholder's] right to cancel this Policy. Such cancellation terminates all coverage under this Certificate.

If a premium is not paid when due, the Company will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*.

Cancellation does not affect a claim when the loss for which the claim is payable occurs before the cancellation date.]

All Certificates under this Policy will terminate on the same date as the Policy.

### **[Premiums**

*(Will be included when coverage is contributory)*

Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for coverage under this Certificate will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect for [Insured Persons] and the premium mode selected, as shown in the *Schedule of Benefits*. [The Company will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder [and/or any affected Subscribers].]

### **[Premium Payment**

*(Will be included when coverage is contributory)*

#### **[1. Policyholder**

The total premium paid by the Policyholder is the sum of premiums for all [Insured Persons] [Optional, i.e. Included only when contributory coverage is offered: including any amounts contributed toward the cost of the coverage by [Insured Persons]. The initial premium is due on the Policy Effective Date [and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits*.] unless the Policyholder and the Company agree to another mode of premium payment. Premiums are paid at the Company's home office or to the Company's authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.]

#### **[2. Subscriber**

The total premium paid by the Subscriber is the sum of premiums for all [Insured Persons] [Optional, i.e. Included only when contributory coverage is offered; including any amount contributed toward the cost of the coverage by [Insured Persons]. The initial premium is due on the Subscriber's effective date of participation under this Policy [and each succeeding premium is due on the next succeeding Premium Due Date, as shown in the *Schedule of Benefits*] unless the Subscriber and the Company agree to another mode of premium payment. Premiums are paid at the Company's home office or to the Company's authorized agent.

If any premium is not paid when due, the Subscriber's participation under the Policy will be terminated as of the Premium Due Date of the unpaid premium, except as provided in any applicable Grace Period section.]

### **[Grace Period**

*(Will be included when coverage is contributory)*

A grace period of [31-180] days will be provided for the payment of any premium due after the first. During the Grace period, coverage under this Certificate shall continue in force, unless the [Policyholder] [Insured Person] has given written notice of discontinuance in advance of the Premium Due date and in accordance with the terms of the Policy. If the required premium is not paid during the Grace Period,

coverage will terminate on the last day of the Grace Period. [The [Policyholder] will be liable for the payment of a pro rata premium for the time the Policy was in force during the Grace Period.]]

[Optional, i.e. Will not be included in non-renewable cases:]

**[Premium Rate Changes**

The Company may change premium rates at the end of any Policy Term [or any Premium Rate Guarantee Period] with at least [31] days advance notice mailed to the last known address of the [Policyholder]. The Company will not increase premium rates more frequently than annually, unless one of the events described below occurs.

The Company may change the premium rate during a Policy Term [or during any applicable Premium Rate Guarantee Period] if any one of the following occurs:

1. the terms of this Policy change;
2. the number of [Insured Persons] [or] [Eligible Persons for coverage] increases or decreases by more than [10%-25%] since the later of the Policy Effective Date and the date of the last renewal of the Policy;]
- [3. coverage is reinstated following failure to pay premium during the Grace Period;]
- [4. an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by [10%-25%] or more the number of [Eligible Person] [Insured Persons];]
- [5. a change in [Insured Persons] [or Eligible Persons to be covered] which would, on a manual rate basis, require a change of [10%-100%] or more in the premium rate;]
- [6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects the Company's benefit obligations under the Policy;]
- [7. the ratio of incurred claims to earned premiums since [the later of the Policy Effective Date and the last renewal date] exceeds [50%-100%]; [or] [the state permissible loss ratio];]
- [8. the [Policyholder] fails to provide sufficient information, as required by the Company, to confirm adequacy of premiums and rates currently being paid;] [or]
- [9. any [facultative] reinsurance obtained by the Company in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by [10%-50%] or more, or the Company retention increases by [10%-50%] or more.]

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.]

**[Premium Audit**

The Company will have the right to audit books and records of the [Policyholder] at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.]

## **GENERAL PROVISIONS**

### **Addition of New [Employees/Members]**

All [Employees/Members] added to the Eligible Class(es) in the *Schedule of Benefits* are eligible for insurance under the group Policy.

### **Entire Contract; Changes**

The Policy, [the master application] and any attached papers make up the entire contract between the Policyholder and the Company. [In the absence of fraud,] all statements made by the Policyholder or any [Insured Person] will be considered representations and not warranties. No written statement made by an [Insured Person] will be used in any contest unless a copy of the statement is furnished to the [Insured Person] or, in the event of the death or incapacity of the [Insured Person], to His beneficiary or personal representative.

No change in the Policy will be valid until approved by one of the Company's executive officers and endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

If an enrollment form for an [Insured Person] is required, it may also be made a part of the Policy at the Company's option.

### **[Certificates**

Where required by law, the Company will provide a Certificate of insurance for delivery to the [Insured Person]. Each Certificate will set forth a statement as to the insurance coverage to which the [Insured Person] is entitled, to whom the insurance benefits are payable.

### **Incontestability**

After an [Insured Person] has been insured under the Policy for two years during His lifetime, no statement made by the [Insured Person], except a fraudulent one, will be used to contest a claim under the Policy. The Company may only contest coverage if the misstatement is made in a written instrument signed by the [Insured Person] and a copy is given to the Policyholder, the [Insured Person] or the beneficiary.

### **[[30 Day] Right to Examine Certificate**

*(Included when the Insured Person pays any part of the premium)*

If the [Insured Person] does not like the Certificate for any reason, it may be returned to the Company within [30] days after receipt. The Company will return any premium that has been paid. In that case the Certificate will be void as if it had never been issued.]

### **Clerical Error**

Clerical error, whether by the Policyholder or the Company, will not void the insurance of any [Insured Person] if that insurance would otherwise have been in effect nor extend the insurance of any [Insured Person] if that insurance would otherwise have ended or been reduced as provided in the Policy.

### **Conformity with State Statutes**

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

### **Misstatement of Fact**

If the [Policyholder] [or Insured Person] has misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased ,had such fact been correctly stated.

### **Noncompliance with Policy Requirements**

Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

### **Policy Changes**

No change in the Policy will be valid until approved by one of the Company's executive officers and

endorsed on or attached to the Policy. The Company may agree with the [Policyholder] to modify a plan of benefits without the [Insured Person's] consent.

**[Subscriber Participation Under This Policy]**

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by the Company.]

**Workers' Compensation**

The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

**Legal Actions**

No action at law or in equity may be brought to recover on the Policy prior to the expiration of [60] days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of [3] years after the time written proof of loss is required to be furnished.

**Assignment**

[An [Insured Person] may not assign any of His rights, privileges or benefits under the Policy.] [An [Insured Person] may assign all of His rights, privileges and benefits under the Policy without the consent of His designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.]

**Physical Examination and Autopsy**

The Company, at its own expense, has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

## **CLAIMS PROVISIONS**

### **Notice of Claim**

Written notice of claim must be given to the Company within [20-90] days after an [Insured Person's] loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company, with information sufficient to identify the [Insured Person], is deemed notice to the Company.

### **Claim Forms**

The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within [15] days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the [Insured Person's] name, the Policyholder's name and the Policy number.

### **Proof of Loss**

Written proof of loss must be furnished to the Company within [90] days after the date of the loss. [In the case of a claim for loss of time for disability, written proof of such loss must be furnished within [30] days after the commencement of the period for which the Company is liable.] If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than 1 year from the time proof is otherwise required.

### **Payment of Claims**

Upon receipt of due written proof of loss, payments for all losses, will be made to (or on behalf of, if applicable) the [Insured Person] suffering the loss. If an [Insured Person] dies before all payments due have been made, the amount still payable will be paid to [the first surviving class of the following classes of persons:

1. Spouse;
2. child or children;
3. parents;
4. siblings; or
5. estate of the [Insured Person].]

[the estate of the [Insured Person].]

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to [a parent, guardian, or other person actually supporting Him] [the legal guardian of the payee's property]. If the payee has no legal guardian for His property, a payment not exceeding \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

### **Time of Payment of Claims**

Benefits payable under the Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon the Company's receipt of due written proof of the loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

### **[Payment of Claims to Foreign Employees**

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to an [Insured Person] whose place of employment is other than:

- [ 1) The United States of America
- 2) Puerto Rico.]

[The Company will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. The Company's payments to the [Policyholder] will constitute a full discharge of the Company's liability for those payments under the Policy.]

**[ERISA Claims**

The Policyholder agrees that the Policy constitutes the plan and plan document under the Employee Retirement Security Act of 1974 as amended (ERISA). The Policyholder designates the Company, or a person or persons which the Company designates, as the claims fiduciary of this plan and gives the Company, or its designee, the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The Policyholder agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and the Company's designation and authority as claims fiduciary.]

**Economic Sanctions Provision**

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

## **DESCRIPTION OF BENEFITS**

This Description of Benefits section describes the Benefits provided by this Policy. Benefit amounts, benefit periods, [any applicable aggregate] [and] [benefit-specific maximums] are shown in the *Schedule of Benefits*. Please read these and the Limitations and Common Exclusions sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

[Please see the *Schedule of Benefits* for the applicability of these benefits on a class level.]

### **Disability Benefits**

The Company will pay Disability Benefits if an [Insured Person] becomes Disabled while covered under the Policy. A Disabled [Insured Person] [must satisfy the Benefit Waiting Period as shown in the *Schedule of Benefits* and] be under the Appropriate Care of a Physician. Satisfactory proof of Disability must be provided to the Company, at the [Insured Person]'s expense, before benefits will be paid.

The Insurance Company will require continued proof of the [Insured Person's] Disability, provided at the [Insured Person]'s expense, for benefits to continue.

### **Disability Benefit Calculation**

Disability Benefits are payable as shown in *the Schedule of Benefits*. Disability Benefits are based on the number of days in a normally scheduled workweek for the [Insured Person] immediately prior to Disability. They will be pro-rated if payable for any period less than a week.

### **Waiver of Premium**

The Company will waive premium for an [Insured Person] during the period of Disability for which the Disability Benefit is payable under the Policy if:

1. Disability began while the [Insured Person] was insured under the Policy; and
2. Disability has existed continuously for a period of not less than one pay period. The pay period must be at least [14] days.

During this period, the [Insured Person]'s insurance will remain in force. This provision is subject to the Termination of Disability Benefits provision, except for the payment of premium.

### **[Return to Work Incentive**

The Return to Work Incentive is shown in the *Schedule of Benefits*. An [Insured Person] may work for wage or profit while Disabled. In any week in which the [Insured Person] works and a Disability Benefit is payable, the Return to Work Incentive applies.]

### **[Lump Sum Payments**

Other Income Benefits or earning paid in lump sum will be prorated over the period for which the sum is given. If no sum is stated, the lump sum will be prorated over five years.]

### **Assumed Receipt of Benefits**

The Company will assume the [Insured Person] is receiving benefits for which they are eligible from Other Income Benefits. The Company will reduce the [Insured Person's] Disability Benefits by the amount from Other Income Benefits it estimates are payable to the [Insured Person].

### **Termination of Disability Benefits**

Disability Benefits will end on the earliest of the following dates:

1. [the date an [Insured Person] earns more than [60-100%] of His Basic Earnings; ]
2. the date the [Insured Person] is no longer Disabled;
3. the end of the Maximum Benefit Period as shown in the Schedule of Benefits;
4. the date an [Insured Person] dies;
5. [the date an [Insured Person] attains the age [60-100];]
6. the date the [Insured Person] is no longer receiving Appropriate Care; or
7. the date the [Insured Person] fails to submit proof of continuing Disability.

8. the date the [Insured Person] refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
9. the date the [Insured person] fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

[Benefits may be resumed if the [Insured Person] cooperates fully in the Rehabilitation Plan within [14-30] days of the date benefits are terminated.]

## **LIMITATIONS**

### **[Pre-Existing Condition Limitation**

Benefits under this Certificate are not payable in connection with a Pre-Existing Condition.

This Pre-Existing Condition Limitation shall not apply commencing after the earlier of:

1. the end of a continuous period of [6, 12, 24] months commencing on or after the [Insured Person's] Coverage Effective Date, during all of which the [Insured Person] has received no medical advice or treatment in connection with such disease or physical condition; and
2. the end of the [one; two] year period commencing on the [Insured Person's] Coverage Effective Date.]

### **[Effect of a Pre Existing on an Increase in Benefits**

If there is an increase in an [Insured Person's] benefits due to an amendment of the plan or the [Insured Person's] enrollment in another option, a benefit limit will apply if the [Insured Person's] Disability is due to a Pre-existing Condition.

Benefits will be limited to the benefits the [Insured Person] had on the day before the increase if the [Insured Person's] Disability begins within [6-24] months of the date the [Insured Person's] increase in benefits under the Policy becomes effective.]

### **[Special Rules For Pre Existing Condition if the [Insured Person] was Covered Under His Employer's Prior Plan.**

Special rules apply to Pre Existing Conditions if the Policy replaces the [Insured Person's] Prior Plan and;

1. the [Insured Person] was insured under that plan on the day before the Policy became effective; and
2. the [Insured Person] became insured under the Policy within [31] days of its Policy Effective Date.

The special rules are:

1. the Employer's prior plan did not have a Pre- Existing Condition exclusion or limitation, then a Pre Existing Condition will not be excluded or limited under this Certificate.
2. if the Employer's prior plan did have a Pre-Existing Condition exclusion or limitation, then the limited time does not end [6-24] months after the effective date of coverage. Instead it will end on the date any equivalent limit would have ended under the Employer's Prior Plan.
3. if the change from the Employer's Prior Plan to this Policy would result in an increase to the amount of benefits for an [Insured Person], the benefits for an [Insured Person's] Disability that is due to a Pre Existing Condition will not increase. Instead benefits are limited to the benefit amount the [Insured Person] had on the date before the plan change. This applies whether or not the Employer's Prior Plan had a Pre- Existing condition exclusion or limitation.]

## **COMMON EXCLUSIONS**

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following [unless coverage is specifically provided for by name in the Description of Benefits section]:

- [1. Attempted suicide, or whenever an [Insured Person] injures Himself on purpose.]
- [2. War or any act of war, whether or not declared.]
- [3. Serving on full-time active duty in any armed forces. If the [Insured Person] sends proof of military service, the Company will refund the portion of the premium paid to cover the [Insured Person] during a period of such service.]
- [4. Active participation in a riot.]
- [5. Commission of a felony.]
- [6. Incarceration in a penal or corrections institution.]
- [7. Participation in an activity or event while under the influence of a controlled substance (unless administered by a Physician or taken according to a Physician's instructions) or Intoxicated. Intoxicated means that condition as defined by the law of the jurisdiction in which the activity or event occurred.]
- [8. Any cosmetic surgery or surgical procedure that is not medically necessary.]
- [9. An Injury or Sickness for which the Employee is paid benefits under any Workers' Compensation or occupational disease law or under any insurance policy that provides benefits to the [Insured Person] for injuries resulting from an occupational accident.]
- [10. The [Insured Person's] refusal to participate in rehabilitation efforts as required by the Company.]
- [11. The [Insured Person] is not receiving Appropriate Care.]
- [12. The [Insured Person] fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]
- [13. [The revocation, restriction or non-renewal of an [Insured Person's] license, permit or certification necessary to perform the duties of His occupation unless due solely to Injury or Sickness otherwise covered by the Certificate/Policy.]
- [14. An Injury or Sickness that is work related.]

## **CONSUMER INFORMATION NOTICE**

### **The Insurance Company may be contacted at:**

Axis Insurance Company  
[Admin. Office: 1 University Square Drive, Suite 200  
Princeton, NJ 08540  
1-800-123-4567]

### **The Insurance Agent may be contacted at:**

[Joseph Agent  
123 Main Street  
Anytown, AR 12345  
1-800-234-5678]

### **The State Insurance Department may be contacted at:**

Arkansas Insurance Department  
[1200 West Third Street  
Little Rock, AR 72201-1904  
1-800-282-9134 or (501) 371-2640]

[Logo]

AXIS INSURANCE COMPANY  
(AN ILLINOIS COMPANY)

**[PARTICIPATING EMPLOYER] GROUP [MASTER] INSURANCE APPLICATION**

Application is hereby made for a plan of INSURANCE based on the following statements and representations:

**[Please attach final approved proposal # \_\_\_\_]**

**Section 1. [Employer/Policyholder/Client] Information**

Name of Applicant \_\_\_\_\_  
(legal name of business entity)

DBA (if applicable) \_\_\_\_\_

Policy Situs state \_\_\_\_\_ SIC Code \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Taxpayer ID#: \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

[Applicant is a: Employer Association Union Other \_\_\_\_\_]

[List all states where [Employees] reside: \_\_\_\_\_  
\_\_\_\_\_]

[Are [Employees] of any affiliate or subsidiary companies to be covered? Yes No  
(If yes, please complete the following for each such affiliate/subsidiary. Attach separate sheet if needed.):

Company Name	Address	Total Employees	Nature of Business	SIC Code	NAIC	D&B

**Section 2. Program Information**

Requested Effective Date \_\_\_\_\_ Enrollment Period: \_\_\_\_\_

[Subject to approval of the Employer's participation in the Ternian Employer Trust, insurance will be effective as of the requested date.]

[Current Medical Plan in place?  Yes  No Current Insurer: \_\_\_\_\_]

Number of Eligible [Employees] \_\_\_\_\_ Number Currently Enrolled: \_\_\_\_\_

Contributory  100% Employee Paid If no, Class/Contribution Amount: \_\_\_\_\_

Eligibility Waiting Period: \_\_\_\_\_

Non-Contributory

[Group Underwriting:

Avg. Age \_\_\_\_\_ %Female Population \_\_\_\_\_ % [Employee] Turnover \_\_\_\_\_]

[Enrollment Options (subject to availability):

[Hospital Indemnity	[Critical Illness	[Dental	[Short-Term Disability	[Outpatient Accident Medical	[Vision
[Plan 1 \$XX Plan 2 \$XX Plan 3 \$XX]	[Plan 1 \$XX Plan 2 \$XX Plan 3 \$XX]	Yes]	Yes]	[Plan 1 \$XX Plan 2 \$XX Plan 3 \$XX]	Yes]
[Spouse Only]	[Spouse Only]			[Spouse Only]	
[Dependent Children Only]	[Dependent Children Only]			[Dependent Children Only]	
[Family Coverage]	[Family Coverage]			[Family Coverage]	

**[Section 3. Administrative Information**

Premium Collection:  Payroll Deduction       Direct Billing       Other \_\_\_\_\_  
 Frequency:       Weekly       Bi-weekly       Monthly       Other \_\_\_\_\_  
 Billing Administration :  List Bill     Electronic Payroll transfer     Other \_\_\_\_\_ ]

**Disclosures; Applicant’s Acceptance of Terms**

Any insurance provided pursuant to this Application shall be subject to all terms and conditions of the Policy issued. It is understood and agreed that only officers of AXIS Insurance Company (“Company”)—*not your insurance broker*—are authorized to change, enlarge, vary or waive any requirements of the Policy. No such change, enlargement, variance or waiver shall be valid unless made a part of the Policy by amendment or other written agreement.

If any Employee (or Spouse or Dependent if such coverage is elected) is not in Active Service on the date his coverage is scheduled to become effective, his coverage shall not take effect until he returns to Active Service.

***Applicant understands that any insurance provided shall take effect on the effective date approved by the Company, and that Applicant should not cancel any predecessor policy or plan until notified by the Company that this Application has been approved.***

**[Signature of Participating Employer and Request for Participation:**

I am an authorized officer of the undersigned employer and understand and agree that the employer/applicant:

- Wishes to become a participating employer in the Ternian Employer Trust (“Trust”), a multiple employer trust established in Delaware. The Trustee is Wilmington Trust Company.
- Desires this to serve as our application to become a participating employer in the Trust for our applicable industry classification and to receive insurance coverage under the Master Policy(ies) issued to the Trust.
- Is familiar with the rules of eligibility and understand that the issuance of the insurance for which we are applying is subject to the written approval of the Company. If the Company does not approve this Application, no insurance will become effective.
- Understands the benefits provided by the Company are subject to the terms of the group insurance policy(ies) issued to the Trust, as amended from time to time, and that these group insurance policies may be terminated by the Company following due notice to the Trustee.
- Shall remit to the Company, regularly in advance, the required premium contributions for insurance benefits, and understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the 31 day grace period. In that case we will owe and agree to pay the premium due for the grace period.
- Shall offer the insurance provided under the group polic(ies) to all eligible present and future new employees. We also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this Application may be cancelled as of any premium due date if the participation requirements are not maintained.
- Certifies that all information contained in this Application is true and complete to the best of my knowledge and belief. ]

[Where required by state, Fraud Warning will be inserted before signature line. See Fraud Warning Important Notice sheet attached.]

Dated at _____ (city, state) on _____ (date) <b>POLICYHOLDER</b> <b>SIGNATURE</b> <hr style="border: 0.5px solid black;"/> Authorized Signature of Applicant <hr style="border: 0.5px solid black;"/> Printed or typed name of Applicant’s Authorized Representative
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<b>LICENSED BROKER/AGENT</b> <b>SIGNATURE</b> <hr style="border: 0.5px solid black;"/> Licensed Broker/Agent <hr style="border: 0.5px solid black;"/> License Number
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## Important Notice

- ❖ ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the District of Columbia: WARNING:*** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ❖ ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ❖ ***For residents of Maine, Tennessee, Virginia and Washington:***  
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Maryland and Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ❖ ***For residents of New York:*** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ❖ ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ❖ ***For residents of Oklahoma: WARNING:*** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ❖ ***For residents of 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.

[LOGO]

**AXIS INSURANCE COMPANY**  
**(A Stock Company)**  
[11680 Great Oaks Way, Ste. 500  
Alpharetta, GA 30022]

**GROUP INSURANCE POLICY [CERTIFICATE] AMENDMENT**

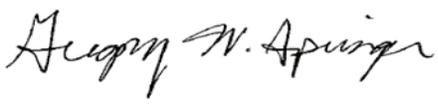
*(This amendment form is being filed as variable in its entirety, but only for the purpose of amending or renewing the policy within the parameters of filed variables.)*

This Amendment is attached to and made part of the Policy effective [Month Day, Year] at 12:01 AM, Standard Time. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Amendment.

This Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Amendment.

The President and Secretary of AXIS Insurance Company witness this Amendment:

[  
  
] Secretary

[  
  
] President

SERFF Tracking #:

PLIS-128686510

State Tracking #:

Company Tracking #:

GSTD-AR

State: Arkansas

Filing Company:

Axis Insurance Company

TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term

Product Name: Group Short Term Disability

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	09/19/2012
Comments:			
Attachment(s):			
Readability-Certification-AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	09/19/2012
Comments:	New Master Application included under the Form Schedule tab along with the other new policy forms.		

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved	09/19/2012
Comments:			
Attachment(s):			
cover letter-GSTD-AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	List of Forms	Approved	09/19/2012
Comments:			
Attachment(s):			
list of forms-GSTD-AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variable Language	Approved	09/19/2012
Comments:			
Attachment(s):			
Statement of Variable Language-GSTD-AR.pdf			

Item Status:

Status Date:

**SERFF Tracking #:**

PLIS-128686510

**State Tracking #:**

**Company Tracking #:**

GSTD-AR

**State:**

Arkansas

**Filing Company:**

Axis Insurance Company

**TOI/Sub-TOI:**

H11G Group Health - Disability Income/H11G.002 Short Term

**Product Name:**

Group Short Term Disability

**Project Name/Number:**

/

Satisfied - Item:	Authorization	Approved	09/19/2012
Comments:			
Attachment(s):			
Authorization.pdf			

## READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Flesch Score
T-GSTD-001-0112-AR	Policy	45 *
T-GSTD-002-0112-AR	Certificate	45
T-GM-003-0112	Master Application	45 *
T-GM-005-0112	Amendment Form	56
	* Policy and Master Application scored 45.3 combined	

Axis Insurance Company

*Christopher N. DiSipio*

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Christopher N. DiSipio  
Senior Vice President

September 12, 2012

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Date

# PLISKY PLISKY & CO. LLC

617 UNION AVENUE, UNIT 1-21   ◇   BRIELLE, NJ 08730   ◇   PHONE: (732) 223-0770   ◇   FAX: (732) 223-1776

September 12, 2012

Arkansas Insurance Department  
Life & Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

RE:   **Axis Insurance Company**    **NAIC#: 3416 37273 / FEIN#: 39-1338397**  
      **Group Short Term Disability** **TOI: H11G.002**  
      Policy                        Form # T-GSTD-001-0112-AR  
      Certificate                 Form # T-GSTD-002-0112-AR  
      Master Application         Form # T-GM-003-0112  
      Amendment Form            Form # T-GM-005-0112

Dear Sir or Madam:

On behalf of AXIS Insurance Company, Plisky Plisky & Co., LLC is submitting the captioned forms for your review and approval. Please find enclosed a letter of authorization. The subject forms are new and are not intended to replace any other forms.

These Group Short Term Disability policy forms provide a weekly lump sum benefit to insureds who become disabled as defined in the policy forms.

This coverage will be marketed by licensed agents, brokers, and third party administrators to Employer groups and employment-related group policyholders including but not limited to: labor unions, PEO's, independent contractors, association groups, and discretionary groups. This coverage may also be offered in your state pursuant to an out-of-state group or trust. Depending on plan design, the Policy may be issued on a non-contributory or contributory basis.

Any bracketed material is being filed as variable. Please note, variable information will never be less favorable to an insured than the minimum statutory and regulatory requirements of your state when issued. Any numeric variables will vary to ranges shown and will comply with minimum statutory/regulatory requirements. Statements of Variable Language are included to provide you with an explanation of how these forms may vary to accommodate different plan designs, or specific clients/cases.

Axis Insurance Company assures your Department that a Guaranty Association Notice will be provided as required.

Master Application Form T-GM-003-0112 is a multi-coverage form that will be used with this product. The form will detail the benefits offered to the Policyholder and will be signed by the Policyholder. Amendment Form T-GM-005-0112 is an administrative amendment that will be used to amend the Policy or Certificate to reflect changes that occur within variable areas subsequent to the initial issuance.

If you have any questions, please contact me directly at (732) 223-0770 or [j.plisky@verizon.net](mailto:j.plisky@verizon.net).

Sincerely,



John M. Plisky, Consultant

Axis Insurance Company  
Group Short Term Disability

LIST OF FORMS

Policy	T-GSTD-001-0112-AR
Certificate	T-GSTD-002-0112-AR
Master Application	T-GM-003-0112
Amendment Form	T-GM-005-0112

**AXIS Insurance Company**  
**STATEMENT OF VARIABLE LANGUAGE**  
**for**  
**Group Short Term Disability Policy Forms**  
**T-GSTD-001-0112-AR, et al.**

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

<b>GENERAL</b>	<p>Any bracketed material is being filed as variable. Please note, variable information will never be less favorable to an insured than the minimum statutory and regulatory requirements of the state where the policy is issued. Any numeric variables will vary to ranges shown and will comply with minimum statutory/regulatory requirements.</p> <p>Brackets around numbers or alphas in listing, and punctuation/words such as “and/or” in a listing, will be included or deleted as needed in order to make the statement or provision read correctly.</p> <p><b>In some instances, we have provided comment as to how the provision/language will be used, within the policy itself. Said comment is in parentheses and italics.</b> E.g., a comment may state that the following language will only be included when an insured contributes to premium, and thus is not included when coverage is non-contributory.</p> <p>This coverage will be marketed to the groups listed in the cover letter. Depending on plan design, the Policy may be issued on a non-contributory or contributory basis.</p> <p>The description of eligible classes may vary based on the nature of the group and classes covered. References to members of the group throughout the forms will vary to reflect group-type, e.g., employee, member, insured person, etc. Likewise, reference to Insured Person may vary to reflect group type.</p> <p>Reference to Spouse may also include a Same Sex Spouse where same sex marriage is recognized or Domestic Partner where said coverage is required or permitted by state law. Reference to Domestic Partner may vary to reflect the proper designation allowed by state law, e.g., Partner to a Civil Union.</p> <p>The format may vary according to plan design or policyholder preference; however the relative prominence of provisions will not change. Subject to state readability laws, the print size, style, page size and layout may be modified to reflect various formats including 8.5 x 11 pages, booklets or brochure styles.</p>
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**POLICY – T-GSTD-001-0112-AR**

<b>Provision/Title</b>	<b>Variable</b>	<b>Description of Variable</b>
<b>FACE PAGE</b>	1	Logo
	2	Title may vary to reflect a marketing name.
	3	Company address may change
	4	Policyholder – John Doe information
	5	Policy Number - John Doe information
	6	Will reflect premium payment mode.

	7	Policy Effective Date - John Doe information
	8	Policy Anniversary - John Doe information
	9	State of Issue – will reflect state where policy is issued
	10	Secretary – signature will be inserted; name may be revised should corporate officer be removed/replaced
	11	President – signature will be inserted; name may be revised should corporate officer be removed/replaced
		Incorporation Provisions – may be included or omitted as per plan design.
		Any bracketed disclosure statements will be included if applicable.
<b>PREMIUM [RATE] TABLE</b>		Table will be included or omitted according to plan design.
	1	Premium modes and rates will vary based on plan design/benefits. Rates will vary by case based on plan of benefits Rates per Policyholder, Subscriber, Insured, Employee, Dependent Spouse, Dependent Child(ren) and Family Plan.
	2	Initial Premium Rate Guarantee -varies by case.
	3	Mode of Premium Payment – varies by case. Values are Monthly, Quarterly, Semi-annual, Annual & Nine months.
	4	Premium Due Dates – varies by case. Can be from January 1 to December 31 of any given year.
	5	Initial Premium will vary by case.
	6	Contributions – varies by case. Policyholder: 0% to 100%; Covered Person and/or Employee – 0% to \$100; Split-funded, Employer & Employee each fund a piece from 0% to 100%.
	7	Will be included when coverage is non-contributory.
<b>PREMIUM PROVISIONS GENERAL PROVISIONS</b>		Provisions shown as variable will be included or omitted according to plan design/benefit structure. Any numeric ranges shown will comply with minimum state statutes or regulations. The range is provided in order to allow for a more favorable time period for the insured person.

### **CERTIFICATE – T-GSTD-002-0112-AR**

<b>FACE PAGE</b>		Logo
		Company address may change
		Date Insurance Takes Effect – will be included: (1) when the policy is contributory; (2) when Actively At Work requirement applies to group policyholder to which the insurance is issued.
		Sections will be included or omitted when applicable to issuance of the certificate.
		Right to Examine Certificate – will be included: when the policy is contributory.
		Secretary – signature will be inserted; name may be revised should corporate officer be removed/replaced
		President – signature will be inserted; name may be revised should corporate officer be removed/replaced
		Disclaimer – The Pre-Existing Condition disclaimer will only appear when required by plan design.
<b>TABLE OF CONTENTS</b>		Page Numbers will vary.
<b>SCHEDULE OF BENEFITS</b>		The Schedule is variable in its entirety and will reflect plan design. The appropriate language will always appear but the arrangement and formatting may vary. Any language required by statute or regulation will always appear and not be excluded or limited. Description of Policyholder will vary to reflect type of group – i.e., Subscriber, Company, Employer name, Policyholder, etc.
		The Schedule Grid shown will include information necessary for

		administration of the product: effective dates, types of coverage, premiums (if contributory) etc.
		Eligible Classes – The description of eligible classes may vary based on the nature of the group and classes covered. References to members of the group throughout the forms may vary, e.g., employee, member, insured person. There is no limit on the number of classes. If there is more than one class eligible under the Policy, a Schedule of Benefits may be presented for each class if benefits, amounts, durations, etc. differ by class.
		Type of Coverage – will be provided when necessary to distinguish between Insured Only and Dependent/Spouse coverage.
		Effective Date – varies by case, it can be any day of the year and is mostly determined by the Policyholder. Rewrite Date will be included when necessary.
		Open Enrollment, Annual Enrollment, or Policyholder Scheduled Enrollment may be selected at the option of the Policyholder.
		Waiting Period and Minimum Number of Hours worked will be included or omitted according to plan design, policyholder and will vary to ranges shown.
		Applicable effective date following enrollment will be included.
		Participation Requirements, Percentages - will be included or omitted according to plan design. Will be included when applicable to the group policyholder.
		Premium information will be included when policy is contributory. Applicable premium, mode, method and due dates will be included.
		Coverage information applicable to a takeover of a policy, necessary for the administration of the policy, may be included. Effective/termination dates, applicable coverage limits and maximums, etc.
		Benefit Waiting Period may be included or omitted. When included it may apply for Accidents, or Sickness, or Hospital. Period will vary to range shown.  The statement about Benefit Waiting Period ending when admitted to hospital will not be included when the Hospital Waiting Period is applicable.
		The Disability Benefit will vary to the ranges shown. There may be options available based on plan design or class. E.g., executive employees may be eligible for a larger max benefit than regular full time employees.  Maximum Benefit Period may be included or omitted and will vary to ranges shown.  Waiver of Premium may be included or omitted.  Rate information will vary based on plan design.
<b>GENERAL DEFINITIONS</b>		Each definition is included or omitted according to plan design. E.g., the Active Service definition will only be included when an insured is required to be in Active Service for coverage under the policy.
		When a definition includes conditions, those conditions may be

		included or omitted according to plan design.
<b>ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS</b>		Provisions shown as variable will be included or omitted according to plan design/benefit structure.
<b>ADMINISTRATIVE PROVISIONS</b>		Provisions shown as variable will be included or omitted according to plan design/benefit structure.
<b>GENERAL PROVISIONS</b>		Provisions shown as variable will be included or omitted according to plan design/benefit structure.
<b>CLAIM PROVISIONS</b>		Provisions shown as variable will be included or omitted according to plan design/benefit structure. Any numeric ranges shown will comply with minimum state statutes or regulations. The range is provided in order to allow for a more favorable time period for the insured person. The ERISA provision will only be included if the plan qualifies under ERISA as per Policyholder contribution.
<b>DESCRIPTION OF BENEFITS</b>		To the extent a benefit requires benefit-specific definitions or exclusions, they will be included or omitted as applicable to the plan design. E.g., when the benefit does not include a Benefit Waiting Period, the definition of Benefit Waiting Period will be omitted. General Definitions and Common Exclusions will also apply.  See section above regarding Schedule of Benefits for how benefits will be paid.
<b>LIMITATIONS AND COMMON EXCLUSIONS</b>		Pre-Existing Condition Limitation will be included or omitted according to plan design. Any exclusions provided in a policy will comply with state rules and regulations. Any language required by statute or regulation will always appear and not be excluded or limited.

### AMENDMENT FORM T-GM-005-0112

Description of Variable
<p>Since the bracketed text in the policy/certificate is variable to be included, omitted or, where applicable, to vary within the numeric ranges displayed within the brackets, this Amendment Form allows us to make changes to previously issued policies/ certificates. Without this Amendment, we'd have to issue new documents each time a change is made. <b>Note that this is <u>not</u> a "blank" amendment. We are asking your Department's approval to use this <u>solely to make changes that are within the variability of the filed forms</u> as set forth above.</b> For example, some of our exclusions and limitations are variable to be included or omitted. With this Amendment we could add or delete such an exclusion or limitation. The Amendment could <u>not</u> be used to add an exclusion that was not part of the original filing and that had not been previously approved by your Department to be included in the policy.</p>

**Master Application Form T-GM-003-0112**

**Description of Variable**

The Title of the Form will vary to how application is being used. May be used as a Master Application for Insurance or an application to become a Participating Employer in a Multiple Employer Trust.

Reference to policyholder may vary depending on the type of Policyholder applying for coverage- i.e., Company, Employer name, etc. Employer-specific requested items will only be included when Employer policyholders are applying for coverage under the policy.

Program information will be included or omitted dependent on plan design being offered. Enrollment Options will vary depending on plan designs being offered. May include product marketing names such as "VisionCare", etc. Selections will reflect plan design being offered.

Reference to Dependent Coverage will be included where such coverage may be selected by the applicant. Any reference to Spouse includes same-sex spouse and/or Domestic Partner where allowed by law.

Administration Information will be included or omitted depending on how plan will be administered.

Request for Participation will only be included when the form is utilized as a Participating Employer Application.

Important Notice Page showing state-specific Fraud Warnings will always be included.



January 12, 2012

**Re: AXIS Insurance Company  
NAIC Company Number: 37273  
Group Filing Submissions**

To Whom It May Concern:

Plisky Plisky & Co. LLC is hereby authorized to submit rate and form filings on behalf of AXIS Insurance Company. This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed to be in effect until rescinded in writing.

Please direct all correspondences and inquiries related to this filing to John Plisky at the following address:

John M. Plisky, President  
Plisky Plisky & Co. LLC  
617 Union Ave., Unit 1-21  
Brielle, NJ 08730  
[j.plisky@verizon.net](mailto:j.plisky@verizon.net)  
ph: (732) 223-0770  
fax: (732) 223-1776

Please contact me if you have any questions regarding this authorization.

Sincerely,

A handwritten signature in cursive script that reads "Megan K. Morehead".

Megan K. Morehead, Esq.  
Assistant Vice President - Compliance  
AXIS Global Accident & Health  
Office: 609-375-9117  
Mobile: 609-216-3342  
[Megan.Morehead@AXIScapital.com](mailto:Megan.Morehead@AXIScapital.com)

