

State: Arkansas **Filing Company:** Madison National Life Insurance Company, Inc.
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.
Product Name: Group Term Life - GBG
State: Arkansas
TOI: L04G Group Life - Term
Sub-TOI: L04G.500 Other
Filing Type: Form
Date Submitted: 01/02/2013
SERFF Tr Num: MADS-128830655
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Re-opened
Co Tr Num: GTL-GBG MNL

Implementation: 02/18/2013
Date Requested:
Author(s): Julie Guess
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/28/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

General Information

Project Name: GTL GBG MNL
Project Number: GTL GBG MNL
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 01/28/2013
State Status Changed: 01/25/2013
Created By: Julie Guess
Corresponding Filing Tracking Number: MADS-128831698

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 01/04/2013
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:
Deemer Date:
Submitted By: Julie Guess

Filing Description:

This is a submission of new forms for Madison National Life Insurance Company, Inc. (MNL). The forms do not replace any forms currently on file with your department. The forms are a Group Term Life and/or Accidental Death & Dismemberment (AD&D) Insurance product intended to be issued to employer groups situated in your state. The Group Term Life/AD&D Policy will be issued directly to the employer. A Certificate of Coverage will be issued to employees.

Please note, the identical policy forms, with the exception of the company name, are also being submitted today for our sister insurance company, Standard Security Life Insurance Company of New York. Our hope is that review of the filings could be coordinated internally so that either the same examiner reviews both, or, if assigned to different examiners, that they be informed of the submission of the identical filings. We think this will be beneficial to both the Department/Division and us, as it may expedite review of the filings and result in consistent changes, if any, being made to the policy forms.

The form numbers included in this submission:

GTL-P-GBG-1112 – Group Term Life/AD&D Master Policy (policy)
GTL-C-GBG-1112 – Group Term Life/AD&D Certificate of Coverage (certificate)
INTL-MLD-APP-ER 0812 - Employer Application
INTL-MLD-APP-EE 0812 - Employee Enrollment/Application

Please note that the Policyholder Application and Enrollment Form are combined applications and are also being filed for use with the Group Major Medical product that will be issued by Madison National Life Insurance Company, Inc's sister company Independence American Insurance Company.

The coverage provides Term Life and/or AD&D benefits to eligible employees. The coverage will be issued to employer groups who have a substantial population of Expatriate, Inpatriate, and Local National employees.

The employer selects the coverage to be issued. The coverage may be issued in one of three formats:

Group Term Life coverage
Group Accidental Death and Dismemberment coverage
Group Term Life and Accidental Death and Dismemberment coverage

Variable material is shown in brackets. Variable text will never exclude or limit provisions required by your state. Generally, any provision in brackets may be included in the forms issued or may be removed in accordance with the plan options offered to groups and the election made by the groups applying. Bracketed time frames and amounts within the provisions include the available ranges. Bracketed text within the provisions will either be include or omitted, unless there are 2 options shown with a

State: Arkansas **Filing Company:** Madison National Life Insurance Company, Inc.
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

"/" separating the options. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary.

The forms have been filed in Wisconsin (for MNL) and may be used beginning January 4, 2013.

Please note the following:

- Sale of the product will be through properly licensed agents and brokers.
- Forms are being submitted in final format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less than that required by your state. We also retain the right to correct grammar and spelling errors as long as those corrections do not change the intent or purpose of this filing.
- Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

Company and Contact

Filing Contact Information

Julie Guess, Compliance Specialist jag@madisonlife.com
 PO Box 5008 800-356-9601 [Phone] 2062 [Ext]
 Madison, WI 53705 608-830-2710 [FAX]

Filing Company Information

Madison National Life Insurance Company, Inc.	CoCode: 65781	State of Domicile: Wisconsin
1241 John Q. Hammons Drive	Group Code: 450	Company Type: Life and Health
Madison, WI 53717	Group Name:	State ID Number:
(800) 356-9601 ext. [Phone]	FEIN Number: 39-0990296	

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50 per form x 4 forms = \$200.00
 Our state of domicile does not charge a filing fee.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Madison National Life Insurance Company, Inc.	\$200.00	01/02/2013	66181575

SERFF Tracking #:

MADS-128830655

State Tracking #:

Company Tracking #:

GTL-GBG MNL

State: Arkansas
 TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
 Product Name: Group Term Life - GBG
 Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/28/2013	01/28/2013
Approved-Closed	Linda Bird	01/09/2013	01/09/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/09/2013	01/09/2013

Response Letters

Responded By	Created On	Date Submitted
Julie Guess	01/09/2013	01/09/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Term Life Master Policy	Julie Guess	01/25/2013	01/28/2013
Form	Group Term Life Certificate of Coverage	Julie Guess	01/25/2013	01/28/2013

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Disposition

Disposition Date: 01/28/2013

Implementation Date:

Status: Approved-Closed

Comment: Company has made corrections to the original submission approved on 01/09/2013.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Form (revised)	Group Term Life Master Policy		Yes
Form	Group Term Life Master Policy	Replaced	Yes
Form (revised)	Group Term Life Certificate of Coverage		Yes
Form	Group Term Life Certificate of Coverage	Replaced	Yes
Form	Combination Employer Application		Yes
Form	Combination Employee Enrollment Form		Yes

SERFF Tracking #:

MADS-128830655

State Tracking #:**Company Tracking #:**

GTL-GBG MNL

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life - GBG

Project Name/Number:

GTL GBG MNL/GTL GBG MNL

Disposition

Disposition Date: 01/09/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		No
Form (revised)	Group Term Life Master Policy		Yes
Form	Group Term Life Master Policy	Replaced	Yes
Form (revised)	Group Term Life Certificate of Coverage		Yes
Form	Group Term Life Certificate of Coverage	Replaced	Yes
Form	Combination Employer Application		Yes
Form	Combination Employee Enrollment Form		Yes

State: Arkansas **Filing Company:** Madison National Life Insurance Company, Inc.
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/09/2013
Submitted Date	01/09/2013
Respond By Date	02/11/2013

Dear Julie Guess,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments: Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

*Sincerely,
Linda Bird*

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/09/2013
Submitted Date	01/09/2013

Dear Linda Bird,

Introduction:

Response 1

Comments:

The certification regarding compliance with Regulation 19 is attached under Supporting Documentation. I apologize for the omission at the time of filing.

Related Objection 1

Comments: Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Flesch Certification
Comments:	
Attachment(s):	AR GA Notice 0110.pdf Readability - MNL cert, pol, INTL app, enroll.pdf AR CompNotice MNL 0210.pdf Certification.pdf
<i>Previous Version</i>	
Satisfied - Item:	<i>Flesch Certification</i>
Comments:	
Attachment(s):	<i>AR GA Notice 0110.pdf Readability - MNL cert, pol, INTL app, enroll.pdf AR CompNotice MNL 0210.pdf</i>

SERFF Tracking #:

MADS-128830655

State Tracking #:

Company Tracking #:

GTL-GBG MNL

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life - GBG

Project Name/Number:

GTL GBG MNL/GTL GBG MNL

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Julie Guess

SERFF Tracking #:

MADS-128830655

State Tracking #:

Company Tracking #:

GTL-GBG MNL

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life - GBG

Project Name/Number:

GTL GBG MNL/GTL GBG MNL

Amendment Letter

Submitted Date: 01/28/2013

Comments:

Ms. Bird -

We've made some corrections to the forms. We have not issued the forms and would like to replace them without changing the form numbers, if possible. The corrections are listed below.

1. GTL-C-GBG-1112 (certificate)- The "Facility of Payment" provision was included twice in the certificate - once in the "Beneficiary and Claims Provisions" and also in the "General Provisions". We removed the text from General Provisions.
2. Added brackets to items A.4. and A.5. in the Termination section. Those items will be included or omitted, depending on the issued coverage in the certificate.
3. Correction to when coverage ends after the Grace Period. Coverage now ends at the end of the Grace Period instead of the "paid to" date. Correction was made in the certificate and in GTL-P-GBG-1112 (policy).
4. Removed item 7 from the "Renewability and Termination" section of the policy. Item 7 referred to health coverage.
5. Added "Termination and Amendment of this Group Policy" provision of the policy.

Please feel free to contact me if you have any questions.

Thank you.

Julie Guess

Compliance Specialist

800-356-9601, ext 2062

jag@madisonlife.com

Changed Items:

SERFF Tracking #:

MADS-128830655

State Tracking #:

Company Tracking #:

GTL-GBG MNL

State: Arkansas
 TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
 Product Name: Group Term Life - GBG
 Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group Term Life Master Policy	GTL-P-GBG-1112	POL	Initial		40.100	GTL-P-GBG-1112.pdf	Date Submitted: 01/28/2013 By:
<i>Previous Version</i>								
1	Group Term Life Master Policy	GTL-P-GBG-1112	POL	Initial		40.100	GTL-P-GBG-1112.pdf	Date Submitted: 01/02/2013 By: Julie Guess
2	Group Term Life Certificate of Coverage	GTL-C-GBG-1112	CER	Initial		48.000	GTL-C-GBG-1112.pdf	Date Submitted: 01/28/2013 By:
<i>Previous Version</i>								
2	Group Term Life Certificate of Coverage	GTL-C-GBG-1112	CER	Initial		48.000	GTL-C-GBG-1112.pdf	Date Submitted: 01/02/2013 By: Julie Guess

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State: Arkansas
 TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
 Product Name: Group Term Life - GBG
 Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Form Schedule

Lead Form Number: GTL-P-GBG-1112								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group Term Life Master Policy	GTL-P-GBG-1112	POL	Initial		40.100	GTL-P-GBG-1112.pdf
2		Group Term Life Certificate of Coverage	GTL-C-GBG-1112	CER	Initial		48.000	GTL-C-GBG-1112.pdf
3		Combination Employer Application	INTL-MLD-APP-ER 0812	AEF	Initial		40.100	INTL-MLD-APP-ER 0812.pdf
4		Combination Employee Enrollment Form	INTL-MLD-APP-EE 0812	AEF	Initial		42.600	INTL-MLD-APP-EE 0812.pdf

Form Type Legend:

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

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Home Office: [1241 John Q. Hammons Drive, Madison, WI 53717]
Administrative Office: [26000 Towne Centre Drive, Foothill Ranch, CA 92610]
(Herein called We, Our, Us or the Company)

POLICYHOLDER: [ABC Company]
EFFECTIVE DATE: [September 1, 2012]
PREMIUM PAYMENT DATE: [monthly, quarterly, semi-annual, annually beginning [September 1, 2012]
RENEWAL DATE: Renewals occur [annually] beginning [September 1, 2012]
POLICY NUMBER: [] (herein called this Policy)
STATE OF DELIVERY: [State]
[ELIGIBLE EMPLOYEE CLASS: [Classes 1-4]]
[WAITING PERIOD: [30-90] days]
[ADMINISTRATOR: [Administrator Name]]
[RIDERS/ENDORSEMENTS: [Name of Rider]]
[ATTACHMENTS: [Policyholder Application, Certificate, Premium Rates]]
[CURRENCY: [US Dollars]]

Madison National Life Insurance Company, Inc. (hereafter called We, Our or Us) agrees to pay group insurance benefits with respect to each Insured Person according and subject to the terms and conditions of this Group Policy (hereafter referred to as Policy). Benefits are payable in United States dollars [or any other currency specifically agreed to in writing by Us]. The benefits and coverage provisions approved under this Policy are contained in the Certificate(s) of Insurance.

This Policy is issued to the Group Policyholder (hereafter referred to as "Policyholder") in consideration of the application and payment of premiums, as provided herein, to take effect as of the Effective Date. A copy of the completed Application is attached. All periods indicated herein shall be deemed to begin and end at 12:01 A.M. Standard Time at the address of the Policyholder. The first premium is due on the Effective Date and renewal premiums are due on the Premium Due Date shown above during the continuance of this Policy.

This Policy includes this page and all Endorsements, Riders, Schedule of Benefits, the Certificates, the Employers' group Application, the Employee Applications and any addendums. These pages are all part of this Policy as if fully recited over the signature shown below. This Policy is issued by Madison National Life Insurance Company, Inc. and delivered to the Policyholder in the state shown above and governed by the laws of the state of delivery. All benefits are provided in accordance with the terms, conditions and provisions of this Group Policy, including all Endorsements, if any, attached to this Group Policy, and applicable state laws. Terms specifically defined in this Policy are limited to that meaning only.

Madison National Life Insurance Company, Inc. has caused this Policy to be executed at its Home Office in Madison, Wisconsin on the Effective Date.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

GROUP [TERM LIFE] [ACCIDENTAL DEATH & DISMEMBERMENT] [TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT] INSURANCE POLICY

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding Us. An application for insurance or claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Group Policy and recovery of any amounts We have paid.

TABLE OF CONTENTS

DEFINITIONS2
CERTIFICATE OF COVERAGE2
EMPLOYER AS EMPLOYEE'S REPRESENTATIVE.....2
PARTICIPATION2
POLICY PREMIUM.....3
RENEWABILITY AND TERMINATION.....4
GENERAL PROVISIONS5
EMPLOYER RESPONSIBILITIES.....6

DEFINITIONS

All terms are as defined in the Certificate of Coverage.

CERTIFICATE OF COVERAGE

The Certificate of Coverage is incorporated into and made a part of this Policy.

The insurance Benefits and Coverage for an Employee are as selected and agreed upon between Us and the Policyholder. All Coverages and actual Benefit amounts in effect with respect to each Employee, and their Dependents, if any, will be as described in the individual Certificate issued by Us to or for that Eligible Employee which will include the Schedule of Benefits and any applicable Riders and Endorsements.

We will make available to each Eligible Employee a Certificate, including a Schedule of Benefits, and applicable Riders/Endorsements, if any, which generally describe, without amending, superseding or changing the Policy in any way, the essential features of coverage to which each Eligible Employee is entitled under this Policy. The Employer is solely responsible for the timely delivery of the Certificate including the Schedule of Benefits, and any applicable Riders/Endorsements, if any, to each of its Eligible Employees. The Employer acts as the agent for, and representative of, its Eligible Employee and their Dependents, if any, when receiving and/or distributing such documents to each Eligible Employee. Madison National Life Insurance Company, Inc. is not liable or responsible in any way whatsoever for any act, omission or statement by the Employer or its agent or representative in connection with this Policy or the delivery of any of these documents.

EMPLOYER AS EMPLOYEE'S REPRESENTATIVE

For any and all purposes regarding the Policy, including each Employee's coverage provided under the Policy, the Employer is neither the agent nor representative of Madison National Life Insurance Company, Inc. The Employer represents only itself and its Eligible Employees under this Policy; its employees, agents and representatives do not represent Madison National Life Insurance Company, Inc., employees, agents and representatives.

Madison National Life Insurance Company, Inc., agents and representatives are not liable or responsible in any way whatsoever for any act, omission or statement by the Employer, its Eligible Employees, Employees, agents or representatives.

PARTICIPATION

Eligibility for Participation: An Employer is eligible to maintain coverage under the Policy for the benefit of its Employees if it:

1. operates a viable business for 52 weeks each Calendar Year;
2. offers coverage to the Eligible Classes it determines on the Effective Date of Coverage;
3. offers coverage to persons eligible for and added to such Eligible Classes after the Effective Date of Coverage;
4. [meets or exceeds the minimum participation requirements; and
5. maintains the required contribution towards premium.]

Eligible Class: The Employer shall determine the Eligible Classes. The Eligible Classes elected by the Employer are shown on the Employer's Application.

An Eligible Employee may fall into one of the following Eligible Classes:

1. **[U.S. Employee]** refers to a person who works and resides in the United States and is employed by the Employer.]
2. **[Expatriate (Expat)]** refers to a person who works and resides outside of their Home Country and is employed by the Employer.]
3. **[Inpatriate]** refers to a non-U.S citizen who has been transferred to work and resides in the Home Country of the Employer.]
4. **[Local National (LN)]** refers to a person who works and resides in the country where he or she is a citizen and is employed by the Employer.]

An Eligible Employee whose Eligible Class is changed after the Effective Date of his coverage shall become eligible under another Eligible Class on the [first day of the month coinciding with or next following][date of eligibility] date specified by the Employer of the change.

Minimum Participation: The Company requires a minimum of [75-85%] participation of Employees of the Employer that are in the Eligible Classes defined under items 2 through 4 above.

POLICY PREMIUM

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Company. Payment must be in the currency approved by the Company, and is due on or before the Premium Payment Date shown on the Policy Face Page. Any other forms of currency shall not be accepted and will be considered as non-payment of Premium unless otherwise agreed by the Company.

Prior to each Premium Payment Date, the Company shall send to the Policyholder an invoice and shall also provide a listing of the Insured Employees. The Policyholder shall update such list with all changes, as well as identifying those Insured Employees who have terminated their employment with the Policyholder, and forward it to the Company together with the payment of the total Premium debit stated on or before the Premium Payment Date. If the list shows a Premium credit, the Company will credit the Policyholder, and apply such credit on the next billing cycle.

1. [The Policy and rates shall be guaranteed for [one year] and are continually subject to the terms in force at the time of each renewal date.]
2. All premiums are payable before coverage under this Policy is provided.

Grace Period: A grace period of 31 days, without interest charge, will be allowed for payment of any premium due after the first premium. The Company will suspend coverage during the specified period if Premium is not received by the Premium Payment Date. If Premium is received within 31 days from the Premium Payment Date, coverage will resume without interruption in coverage. If the Premium due is not paid within the grace period, this Group Policy will end automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period.

If the Company receives written notice by the Policyholder of its intent to cancel the Policy, the Company will cancel the Policy on the later of the following:

1. The date requested by the Policyholder but no greater than 31 days from the date notice was received by the Company, or
2. The date the Company receives the notice.

All unpaid Premium through the date of cancellation is the obligation of the Policyholder and any other premium adjustments assessed as a result of cancellation. There will be a service fee for any checks returned for insufficient funds, closed accounts, or for stop payments on checks. Returned checks will be treated as non-payment of Premiums.

Policy and Rate Modifications

The Policy term begins on the Effective Date of the Policy as shown on the Policy Face Page and ends at midnight prior to the Renewal Date.

The Company has the right to change any Premium, or rate basis, on one of the following:

1. [Any Premium Payment Date: [The Policy and rates shall be guaranteed for one year and are continually subject to the terms in force at the time of each Renewal Date. After the first year, rates will not be changed more often than once every 6 months.] The Company must notify the Policyholder of the change in writing at least 31 days before the Company makes the change; or]
2. Any Renewal Date: The Company must notify the Policyholder of the change at least 31 days before the Company makes the change, or
3. At any time the demographics / location of the Policyholder or employees change.

Other Premium Changes

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:

1. Any mutually agreed upon change in benefits provided under the Policy;
2. Additions, deletions, increases or decreases of an Insured Employee's Dependent's insurance;
3. Addition of a new Insured;
4. Termination of an Insured;
5. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
6. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or

7. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

Any such change will be prorated to the Premium payment period of the Policyholder and reflected on the Policyholder's next billing statement. Continued payment of the appropriate Premium (including payment at changed rates) shall be confirmation of the Insured's acceptance of the Policy or Premium change and will result in the continuation of coverage, as modified, without interruption.

Any other changes relating to Insured Employees (such as change of address or occupation) or of any other material changes that affect information given in connection with the application for coverage under this Policy must be disclosed.

RENEWABILITY AND TERMINATION

Renewability of Policy

The Policy automatically renews on the Renewal Date shown on the Policy face page, except for the following reasons:

1. Non-payment of premiums;
2. Fraud or misrepresentation of or by the Employer, or with respect to coverage of an Insured Person, fraud or misrepresentation by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the contribution and participation requirements;
4. For not maintaining Employee or Dependent participation or contributions requirements;
5. The Insurance Commissioner of the state in which the Employer originally obtained coverage finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders; or
6. The Insurance Commissioner of the state in which the Employer originally obtained coverage finds that the continuation of coverage would impair Our ability to meet Our obligations.

Time For Non-Renewal Of Policy

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

Upon Subscribing to the Policy

The Policyholder shall provide the Company with the following:

1. A complete census, including a list of Eligible Employees, and indicating for each person family name, first name, date of birth, family status, country of assignment, nationality (country of citizenship) and salary, if applicable, and job title,
2. A list of Employees unable to work on the Effective Date of the Policy, and reasons why,
3. Completed Enrollment Forms and any requested Health Questionnaires completed by each Employee. Completed, signed originals must be received within 30 days of the Effective Date of the Policy.

During the Term of the Policy

The Employer agrees to the following:

1. Enroll all new Eligible Employees on hire date as well as all other Employees who become eligible. When enrolling employees, the Policyholder will indicate either the hire date or the date when the employee became an Eligible Employee;
2. Inform the Company, of the name and date of termination of all Insured Employees and/or Insured Dependents that are no longer eligible for coverage under this Policy, within 31 days of the date of termination;
3. Submit a completed Enrollment Form for each Eligible Employee.

Termination or Amendment of this Group Policy

1. This Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of this Group Policy. Any such change or amendment may apply to current eligible persons covered under this Group Policy or to any separate classes or categories thereof.
2. We may change this Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under this Group Policy, or (ii) with the Policyholder's or Employer's consent.

3. We may terminate this Group Policy on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under this Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.
4. Benefits are limited to the terms of this Group Policy, including any valid amendments. No change or amendment of this Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to the Policyholder. The Policyholder and their Eligible Employees or representatives have no right or authority to change or amend this Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

GENERAL PROVISIONS

Representations Not Warranties: Unless fraudulent, all statements made by, or for, an Eligible Person under this Policy are representations and not warranties. No statement can be used to void an Eligible Person's coverage unless a copy of the statement is signed by the Eligible Person and furnished to the Eligible Person or his or her beneficiary.

Incontestability: After an Employer's coverage has been in force two years from its effective date, no statement of the Employer will be used to void the Employer's coverage. No statement by any Eligible Person on a written application for insurance will be used to reduce or deny a claim after the Eligible Person's Coverage, with respect to which claim has been made, has been in effect for two years or more.

Clerical Error: If a clerical error is made so that an otherwise Insured Person's coverage does not become effective, coverage may be in effect if: (a) the Eligible Employee makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the Effective Date of coverage. The Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any premium refund will be reduced by any payment made for claims.

If claims paid exceed the premium refund or if benefits are paid to any person who Madison National Life Insurance Company, Inc. subsequently identifies as not being entitled to coverage under the Policy on the date a claim for benefit was incurred, the Employer will be liable for the amount of the benefits so paid. At Madison National Life Insurance Company Inc.'s option, it will bill the Employer for these amounts or adjust future premiums.

Reinstatement of Policy: If the Policy lapses due to non-payment of the required premiums, the Employer may reinstate the Policy, provided that within 20 calendar days immediately following the expiration of the 31-day Grace Period the Employer makes payment to Us or to Our Authorized Administrator of:

1. All premium remaining unpaid at the expiration of the Grace Period, and
2. The current month's due premium.

An Employer may reinstate the Policy once in any consecutive 24-month period and no Employer will have the privilege to reinstate the Policy more than once during any consecutive 24-month period.

In all other respects, We and the Employer will have the same rights under the Policy existing immediately before the due date of the non-payment of premium.

Non-Participation: This Policy is non-participating. It does not share in the Company's profits or surplus earnings.

Conformity With Laws: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Waiver Of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Electronic Exchange of Data: In the event the Employer and Company exchange data and information electronically, the Employer agrees to transfer on a timely basis all required data to the Company via electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Company, a copy of which shall be furnished to the Employer upon written request to the Company. The Employer authorizes the Company to submit such data and information in the specified electronic format. In the event the Employer is unable or unwilling to transfer data in the specified electronic format, the Company is under no obligation to receive or transmit data in any other format.

The Employer agrees to indemnify and hold harmless the Company from any and all liability arising out of the transfer of such data from the Employer to the Company or from the Company to the Employer. This indemnification also covers claims and or liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmission. If such transmissions occur, Company and the Employer agree to redirect the information via another mutually agreeable means.

EMPLOYER RESPONSIBILITIES

The Employer agrees:

1. To offer each Employee the opportunity to elect coverage under the Policy as a procedure of employment when he or she attains the status of an Employee as provided for in the Policy.
2. To furnish Madison National Life Insurance Company, Inc. or its authorized administrator on a monthly basis and on Madison National Life Insurance Company, Inc. approved forms, such information as may reasonably be required by Madison National Life Insurance Company for the administration of coverage under the Policy, including any change in a Covered Person's eligibility status.
3. To comply with all policies and procedures established by Madison National Life Insurance Company, Inc. in administering and interpreting coverage under the Policy.
4. To furnish all enrollment and termination change notifications to Madison National Life Insurance Company, Inc. or its authorized administrator in a timely manner.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: [1241 John Q. Hammons Drive, Madison, WI 53717]
Administrative Office: [26000 Towne Centre Drive, Foothill Ranch, CA 92610]

[Trade Name]

Group [Life] [Accidental Death & Dismemberment] [Life and Accidental Death & Dismemberment] Insurance Certificate Of Coverage

VALIDATION OF COVERAGE

[Your certificate is validated by the attachment of this Validation of Coverage showing Your name and plan information.]

Policyholder [ABC Company]
Group Policy Number: [Policy No.]
Group Policy Effective Date: [Date]
[Plan [Plan Name]]
Employer Location: [STATE]
[Insured Employee: [As on file with the Administrator]]
[Dependent Coverage: [As on file with the Administrator]]
[Employee Effective Date: [As on file with the Administrator]]
[Dependent Effective Date: [As on file with the Administrator]]
[Administrator: [ABC Administrator]]

The insurance coverage, benefits and the principal provisions that apply to the Insured Person [named above] are summarized in this Validation of Coverage, the Schedule of Benefits and the Certificate of Coverage and are merely evidence of insurance under the Policy. Insurance coverages are subject to the terms of the Policy, which alone constitutes the contract under which payment is made. The Policy is a contract between the Policyholder and Us. It may be changed or terminated only by those parties. Coverage is provided under Group Policy number shown above. Benefits are paid in United States Dollars or any other agreed upon currency specifically agreed to in writing by Us.

THIS FACE PAGE SUPERSEDES AND REPLACES ANY AND ALL
PREVIOUSLY ISSUED TO THE EMPLOYEE [NAMED ABOVE]

[THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S
COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER
YOUR EMPLOYER PARTICIPATES IN THE WORKER'S COMPENSATION SYSTEM AND HAS PURCHASED A
WORKER'S COMPENSATION INSURANCE POLICY.]

ANY PROVISION OF THE CERTIFICATE WHICH IS IN CONFLICT WITH FEDERAL LAWS OR ANY
APPLICABLE STATE LAW IS HEREBY AMENDED TO MEET THE MINIMUM REQUIREMENTS OF THE LAW.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



[Larry R. Graber
President



Adam C. Vandervoort
Secretary]

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding Us. An application for insurance or claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Group Policy and recovery of any amounts We have paid.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	2
SECTION 1 - INTRODUCTION	4
SECTION 2 - ELIGIBILITY FOR INSURANCE, CONDITIONS OF COVERAGE AND EFFECTIVE DATES	4
SECTION 3 – BENEFITS	6
Group Term Life.....	6
Group Accidental Death & Dismemberment (AD&D).....	6
[Accident Permanent Total Disablement	6
[Accumulation Limit	7
[Waiver Of Premium	7
[Living Benefit.....	8
Conversion	9
SECTION 4 - EXCLUSIONS AND LIMITATIONS	10
SECTION 5 – TERMINATION	10
SECTION 6 - PREMIUM PAYMENT	11
SECTION 7 – BENEFICIARY AND CLAIMS PROVISIONS	12
SECTION 8 - GENERAL PROVISIONS.....	13
SECTION 9 – DEFINITIONS	15

SCHEDULE OF BENEFITS

A. Administrative

1. Policyholder:
2. Employer:
3. Plan Number:
4. Plan Effective Date:
5. Enrollment Period: [Annual/Open/Not Applicable] [Month Day, Year to Month Day, Year]
6. Eligible Class: Life Class [Number], [Description]
7. Minimum Hourly Work Requirement: [Number of hours] per [week/month/year]
8. Waiting Period for Insurance Coverage: [[0/30/60/90/180] days/as determined by the Employer]
9. Employee Premium Contribution:
 - Life/AD&D Coverage
 - Employee Basic: [1-100]%
 - [Employee Supplemental: [1-100]%]
 - [Dependent Basic – Family: [1-100]%]
 - [Dependent Basic – Spouse: [1-100]%]
 - [Dependent Basic – Child: [1-100]%]
 - [Dependent Supplemental: [1-100]%]
 - [Retiree: [1-100]%]
10. Insurance Reduction Schedule:
 - Life/AD&D Coverage
 - Employee Basic: [[0-95]% at Age [65-100]]
 - [Employee Supplemental: [[0-95]% at Age [65-100]]]
 - [Dependent Basic – Family: [[0-95]% at Age [65-100]]]
 - [Dependent Supplemental: [[0-95]% at Age [65-100]]]
 - [Retiree: [[0-95]% at Age [65-100]]]
11. Evidence of Insurability Requirements: Applies to Late Enrollees, Increases in Benefits and Amounts over Guarantee Issue Amounts, Reinstatement
12. Total Sum Insured [\$1 - \$750,000]

B. [Life Insurance

- Employee Basic Life: [\$1-\$1,000,000]
- Guarantee Issue: [\$0-\$1,000,000]
- Maximum Issue: [\$1-\$1,000,000]]

- [[Dependent Life
- [Family Basic Life: [\$100-\$50,000]
- Guarantee Issue: [\$0-\$50,000]
- Maximum Issue: [\$100-\$50,000]]

- [Spouse Basic Life: [\$1,000-\$500,000]
- Guarantee Issue: [\$0-\$500,000]
- Maximum Issue: [\$1,000-\$500,000]]

- [Child Life
- Age: Birth through 14 days: [\$0-\$50,000]
- Age: 15 days to 6 months: [\$100-\$50,000]
- Age: 6 months through the Age specified herein: [\$100-\$50,000]
- Guarantee Issue: [\$0-\$50,000]
- Maximum Issue: [\$0-\$50,000]]]

C. [Supplemental Life Insurance

- Employee Supplemental Life: [\$1-\$1,000,000]
- Guarantee Issue: [\$0-\$1,000,000]
- Maximum Issue: [\$1-\$1,000,000]
- [Annual Increase in Coverage – Evidence of Insurability required if the benefit amount exceeds [[10-200]% of Annual Salary / [\$1,000-\$100,000]]

[[Dependent Supplemental Life

[Family Supplemental Life: [\$100-\$50,000]
Guarantee Issue: [\$0-\$50,000]
Maximum Issue: [\$100-\$50,000]]

[Spouse Supplemental Life: [\$1,000-\$500,000]
Guarantee: [\$0-\$500,000]
Maximum: [\$1,000-\$500,000]]

[Child Supplemental Life
Age: Birth through 14 day: [\$0-\$50,000]
Age: 15 days to 6 months: [\$100-\$50,000]
Age: 6 months through Limiting Age: [\$100-\$50,000]
Guarantee Issue: [\$0-\$50,000]
Maximum Issue: [\$0-\$50,000]]]

D. Additional Benefits

- 1. Conversion of Insurance Benefit: Included
- 2. [Waiver of Premium Benefit: Included]
- 3. [Living Benefit: Included]

[E. Accidental Death and Dismemberment

1. AD&D Insurance

Employee AD&D: [\$1-\$1,000,000]
Guarantee Issue: [\$0-\$1,000,000]
Maximum Issue: [\$1-\$1,000,000]

[[Dependent AD&D

Family AD&D: [\$100-\$50,000]
Guarantee Issue: [\$0-\$50,000]
Maximum Issue: [\$100-\$50,000]]

[Spouse AD&D: [\$1,000-\$500,000]
Guarantee: [\$0-\$500,000]
Maximum: [\$1,000-\$500,000]]

SECTION 1 - INTRODUCTION

This Certificate of Coverage is composed of 4 parts:

1. The Validation of Coverage;
2. The Schedule of Benefits;
3. The Certificate; and
4. Any Endorsements or Riders reflected in Your Schedule of Benefits and/or attached to this Certificate of Coverage.

This Certificate of Coverage describes Your eligibility and enrollment requirements, Your benefits, the exclusion and limitations applicable to Your benefits, and those things You need to do in order to be entitled to Your complete benefits. Specific definitions apply to this Certificate of Coverage. Please see the Definitions section of the Certificate of Coverage for definitions of specific terms.

SECTION 2 - ELIGIBILITY FOR INSURANCE, CONDITIONS OF COVERAGE AND EFFECTIVE DATES

ELIGIBILITY

All the employees of the Policyholder who are in an Eligible Class, meet the criteria indicated under Eligible Employees and have met any applicable Policyholder Waiting Periods are eligible for insurance. The Employer shall determine the Eligible Classes. The Eligible Classes elected by the Employer are shown on the Employer's Application, and the Schedule of Benefits.

Eligible Employees

Permanent, full-time Employees of the Employer, who satisfy the Minimum Work Requirement specified in the Schedule of Benefit for the Policyholder[, and are less than 70 years of age at time of enrollment.] [An Eligible Employee or dependent spouse may renew coverage up to age 75.]

[Insured Persons who are terminated from coverage during the Policy Year cannot be reactivated until the following Policy year.]

Eligible Dependents

Provided dependent coverage has been elected, coverage under the Policy can be extended to the following family members as Insured Dependents:

1. Spouse (Spouse includes Domestic Partner), and
2. Children up to age 19. Upon attainment of age 19, coverage will terminate at the end of the Policy Year.

Spouse means a person to whom the Employee is legally married, and not legally separated.

Domestic Partner means a person who lives in the same household and shares the common resources of life in a close, personal intimate relationship with the Eligible Employee provided that such individual would not be prevented from marrying the eligible employee due to age, blood relationship, or prior undissolved marriage to another. Except where otherwise specified, a Domestic Partner will herein be the equivalent of a Spouse.]

Dependent children include the Insured Employee's or the Insured Employee's Spouse's or Domestic Partner's natural children, legally adopted children, child placed for adoption, step children, child for whom the Insured Employee has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Insured Employee in a regular parent-child relationship.

Dependents are eligible for insurance on the later of: (a) the day the Insured Employee becomes eligible; or (b) the day the Insured Employee acquires the dependent. Dependents can only be insured if the Insured Employee is insured by the Policy and has elected Dependent coverage.

Residency

The residence of the primary insured and all dependents is assumed to be the work location assigned by the employer. If the spouse or dependents are living in another location, the Company must be notified in writing of

their full-time residence immediately. Further, it is assumed that the primary insured is residing in the work location assigned by the employer during the employment year. Any change must be immediately reported to the Company.

ENROLLMENT PROCEDURES

Conditions of Enrollment

An employee must be working the minimum number of hours specified in the Schedule of Benefits to be eligible. The employee must also meet the criteria under the section, Eligible Employees.

Coverage under the Policy that is provided on a Non-contributory basis is mandatory for all employees. All Eligible Employees are required to enroll under the plan up to the Guarantee Issue Amount. A waiver of coverage is not permitted. Any amounts of insurance that are Contributory, or in excess of the Guarantee Issue Amount are subject to Evidence of Insurability. Refer to the Schedule of Benefits for your options.

New Hired Employees

The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. Your initial date of eligibility is the first day of Your Waiting Period, which is typically the date on which employment begins. All new hired employees and Dependents added during the Policy Year must enroll within 31 days of the date of eligibility. The addition of such new Insured Persons may be subject to verification of hire date and employment status and/or any additional documents requested by the Company's Enrollment Department.

Employees who do not enroll within 31 days of the date of eligibility or on the Policy renewal date will be considered a Late Enrollee. (See Late Enrollee provision below).

Late Enrollee Eligibility (Employee or Dependent)

An Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period is a Late Enrollee.

Enrollment

If You or Your Eligible Dependent is entitled to enroll under the Policy during an Initial Enrollment Period, You must submit an Enrollment Form for Yourself and/or Your Dependent on or before the applicable enrollment deadline as described in this Certificate. You may obtain an Enrollment Form from Your Employer. The Enrollment Form must be received by Our designated administrator on or before the applicable enrollment deadline as described in this Certificate in order for You not to be considered a Late Enrollee.

Employee Effective Date

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date, after you have met any Employer defined Waiting Periods.
2. If You become eligible after the Employer's Effective Date and enroll during an Initial Enrollment Period, coverage will be effective the [first of the month] [date of eligibility] next following the later of the end of the applicable Waiting Period or receipt of the Enrollment Form by Us.
3. If You are applying for coverage in excess of the Guarantee Issue Amount, the coverage will be subject to Evidence of Insurability with such excess amount becoming effective the [first day of the month] [date of eligibility] next following the date on which We approve the application.

Dependent Effective Date

The Effective Date of a Dependent's coverage under the Policy, excluding a Late Enrollee, depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;
2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;
3. If the Dependent is a new spouse who first becomes eligible after Your Effective Date and You timely enroll the new spouse as described above, coverage will become effective as of the [first day of the month] [date of eligibility] next following the date on which We receive the Enrollment Form;
4. If the Dependent is a newborn Child who is born after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of birth;

5. If the Dependent is an adopted Child or a Child placed for adoption who is adopted or placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or placement for adoption; or
6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the [first day of the month] [date of eligibility] next following the date on which We receive the Enrollment Form.
7. If the Dependent is applying for coverage in excess of the Guarantee Issue Amount, the coverage will be subject to Evidence of Insurability with such excess amount becoming effective the [first day of the month] [date of eligibility] next following the date on which We approve the application.

SECTION 3 – BENEFITS

The Insurer provides group insurance coverage for eligible employees as designated by the Policyholder and agreed by the Insurer. **Refer to the Schedule of Benefits to determine the benefits purchased under the plan of insurance issued to the Policyholder.**

[Group Term Life: The group term life benefit becomes due in the event of the Insured Person's death while still covered under the Policy. The Insurer shall pay the full group term life benefit subject to any exclusions, limitations or coverage restrictions after receiving Proof of Loss. The Life insurance pays a benefit for death by illness or accident subject to all exclusions, limitations, terms and conditions of the Policy.]

[Group Accidental Death & Dismemberment (AD&D): Upon proof that the Insured Person has suffered any of the below outlined losses as a direct consequence of an accident within 360 days from the date of the accident, and provided that such loss is not the direct or indirect result of a risk excluded under the Policy, a benefit becomes payable in accordance with the provisions and limitations as set forth.

In case of dismemberment by accident the maximum benefit payable is as defined in the Schedule shown below. If a dismemberment benefit has been paid to an Insured Person who dies later, while still being covered under the Accidental Death & Dismemberment section, any dismemberment benefit already paid will be subtracted from the Accidental Death benefit should it become due.

Accident shall mean any bodily injury involuntarily sustained by the Insured Person as a consequence of a sudden and unpredictable intervention of external forces.]

AD&D Benefit	Percentage of Benefit
1. [Accidental Death]	[100%]
2. [Total and irrecoverable loss of sight of both eyes]	[100%]
3. [Total and irrecoverable loss of sight of one eye]	[50%]
4. [Loss of two limbs]	[100%]
5. [Loss of one limb]	[50%]
6. [Total and irrecoverable loss of sight of one eye and loss of one limb]	[100%]
7. [Accident Permanent Total Disablement]	[100%]

[One payment of 100% of the AD&D benefit shall exhaust the AD&D benefits per Insured Person. In event of Accidental Death the Policy will pay in addition to the Group Life sum insured (double indemnity).]

[Accident Permanent Total Disablement

Permanent Total Disablement is written on an accident only basis. If the Insured Person is covered by a Long Term Disability policy, this Policy will not pay a benefit in addition to the Long Term Disability benefit.

- This Policy contains a 12-month deferred period.
- Employees: Accident Permanent Total Disablement is defined by Own Occupation.

- Spouses and Dependent Children: Accident Permanent Total Disablement is defined by Activities of Daily Living.]

[Accumulation Limit

The term “accident event” as used herein shall be understood to mean all individual losses arising out of and directly occasioned by one sudden, unexpected unusual specific event occurring at an identifiable time and place. However, the duration and extent of any “accident event” so defined shall be limited to 72 hours and within a 10 mile radius for any “accident event” hereunder, and no individual loss which occurs outside such period and/or radius shall be included in that “accident event”. The Policyholder may choose the date and time when such period of consecutive hours commences and also the specific 10-mile radius determining an “accident event”.

If any event is of greater duration than the above period, the Policyholder may divide that event into two or more “accident events” provided that no two periods overlap and provided no period commences earlier than the date and time of the first recorded individual loss to the Policyholder arising out of the event.

The Accumulation Limit is an amount equal to the Total Sum Insured as shown on the Schedule of Benefits, but not to exceed \$[1-10,000,000.]]

[Waiver Of Premium

A. Waiver of Premium Definitions

1. **Elimination Period** means the period of 9 months beginning on the date You become Disabled.
2. **Life Insurance** under this Waiver of Premium Benefit means all of the Life Insurance, as listed in the Schedule of Benefits, in force under the Group Policy on the day before the day You become Disabled.
3. **Proof of Disability** means documented clinical findings that prove that You are Disabled.

B. Waiver of Premium does not apply to AD&D Insurance.

C. Your Life Insurance will be continued as provided for under this section without payment of premium, if all of the following conditions are met:

1. You become Disabled prior to age 60 while insured under the Group Policy;
2. You remain Disabled without interruption for the duration of the Elimination Period;
3. You provide Us with written notice of Your Disability within 30 days after the end of Your Elimination Period;
4. You provide Us with satisfactory written Proof of Disability within 3 months from the last day of the Elimination Period;
5. Your claim is approved by Us.

B. When the Waiver of Premium Benefit Begins. If You qualify and are approved for the Waiver of Premium Benefit, Your premium will be waived beginning on the first day of the month immediately following the end of Your Elimination Period.

C. When Waiver of Premium Ends. Waiver of Premium ends on the earliest to occur of the following:

1. The date You cease to be Disabled;
2. The 91st day following the date We mail to You a request for additional Proof of Disability with which You fail to comply;
3. The date You refuse to submit to a medical examination or to cooperate with Our chosen health care provider;
4. The date You refuse to submit to or undergo vocational rehabilitation (which determines employment opportunities, if any, for individuals with disabilities);
5. [The date at which You’ve resided outside of the United States of America, or one of its territories during any 6 consecutive months for which premium had been waived;]
6. The effective date of an individual life insurance policy issued to You under the “Life Insurance Conversion Benefit” section.
7. The premium due date immediately prior to Your 65th birthday;
8. The date You Retire, unless such Retirement is due to a Disability.

D. Premiums

1. Premium payment must continue until the later of the end of Your Elimination Period or the date Your claim for the Waiver of Premium Benefit is approved by Us.
2. If Your Waiver of Premium benefit terminates because You cease to be Disabled or You fail to submit to a medical exam or cooperate with the examiner, for coverage to continue, You must be an Eligible Employee and premiums must resume on the next premium due date, or You must continue coverage as provided for under the “Life Insurance Conversion Benefit” section.

- E. Amount of Insurance
 1. The amount of Life Insurance continued under the Waiver of Premium Benefit is the amount in effect on the day before You became Disabled, if you were Actively at Work.
 2. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before You became Disabled.
 3. Your Life Insurance amount will not increase while Your Life Insurance premiums are being waived.
- F. We will not waive premiums if Your Disability results from intentionally self-inflicted Injuries or Physical Diseases, while sane or insane, or from Your voluntary participation in an illegal activity.
- G. If You die during the Elimination Period and are otherwise eligible for the Waiver of Premium Benefit, the Elimination Period will not apply.
- H. We may require further Proof of Disability in intervals that are reasonable based on Your type of Disability.
- I. Investigation Of Claim
 With respect to benefits that are claimed during an Insured Person's lifetime, We may require him or her to undergo examination at reasonable intervals, at Our expense. Any such examinations will be conducted by appropriate Physician of Our choice. We may deny or suspend benefits if You fail to attend an examination, or do not give full effort and cooperation to the examiner.]

[Living Benefit

Terminally Ill and **Terminal Illness** mean a medical condition that is expected to result in Your death within [6-24] months.

- A. If You become Terminally Ill while covered for life insurance under the Group Policy You may elect to receive the Living Benefit as provided for under this section.
- B. The Living Benefit will be an amount equal to [25-100%] of Your Employee Basic Life Insurance [plus Your Employee Supplemental Life Insurance] in effect on the date Your election is made, subject to a minimum of [\$5,000-50,000] and a maximum of [\$25,000-1,000,000]. The amount payable will be equal to the Living Benefit less applicable amounts, if any, charged for an investment loss (interest) and administrative fees.
- C. The payment will be made in one lump sum to You or to the payee You appropriately assign.
- D. The Living Benefit will not be available if:
 1. You have any portion of any Life Insurance or ownership rights thereof absolutely or irrevocably assigned or transferred;
 2. You have made an irrevocable beneficiary designation;
 3. the insurance proceeds are subject to a court order under a divorce decree, separate maintenance agreement or property settlement agreement;
 4. You have filed for bankruptcy, unless You give Us written approval from the bankruptcy court for payment of the Living Benefit; [and]
 5. [Your Terminal Illness resulted from an intentionally self-inflicted injury or suicide attempt within the first two years after Your effective date of coverage or an insurance increase].
- E. No payment will be made under this election unless and until We receive and approve of all of the following:
 1. Your signed and notarized election of this option on a form furnished by Us;
 1. signed and witnessed written statements of all irrevocable beneficiaries and assignees (and Spouse in marital property states) consenting to Your election of this option; and
 2. satisfactory written proof from a Physician other than Yourself or a member of Your or Your Spouse's immediate family that You have been diagnosed as being Terminally Ill and that You are of sound mind and under no constraint or undue influence.
- F. We may require a second opinion and examination of Your condition at Our own expense by a Physician of Our choice.
- G. Payment of the Living Benefit will reduce correspondingly the face amount of Your life insurance benefits under the Group Policy. This will result in reduced life insurance proceeds payable to Your beneficiary at Your death. Furthermore, any amount of insurance that would otherwise be continued [under the "Waiver of Premium

Benefit” section] will be reduced proportionately, as will the maximum face amount available under the “Life Insurance Conversion Benefit” section.

- H. Premium payments must continue to be paid for Your life insurance unless You qualify to have Your life insurance premium waived. [The premium payment due will not be affected by any Living Benefit paid under this provision.][The premium due will be based on the amount of insurance remaining in force after deducting the amount of the Living Benefit.]
- I. Payment of the Living Benefit will not affect the amount of, or change an existing beneficiary designation for, the AD&D Benefit, if any, in effect and kept in force under the Group Policy.
- J. Your election together with Our payment of the Living Benefit constitute a valid and effective beneficiary designation change, but only with respect to the specified life insurance benefits, and only to the extent affected by the Living Benefit payment, and applicable interest and fees, if any, charged thereon.
- J. Payment of the Living Benefit will be exempt from the claims of creditors and from legal process to the extent permitted by law.
- K. All other provisions of the Group Policy, including the effective date provisions of any benefit increases and the provisions on benefit reductions because of amendments to the plan or benefit classification changes or Your attained age, remain valid and in effect. Any such life insurance benefit reduction will be calculated based on Your life insurance amount in effect immediately before the Living Benefit payment.
- M. You are responsible for any tax consequences related to this benefit.]

Conversion

- A. If the insurance, or any portion of it, on an Insured Person covered under the Policy or on the dependent of an Insured Person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the Policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after termination and provided further that:
 - 1. The individual policy shall, at the option of such person, be on any one of the forms then customarily issued by the insurer (except for term insurance) at the age and for the amount applied for.
 - 2. The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of termination, less the amount of any life insurance for which the person becomes eligible under the same or any other group policy within thirty-one (31) days after termination, provided that any amount of insurance which shall have matured on or before the date of termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of termination; and
 - 3. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to the individual age attained on the effective date of the individual policy. Subject to the same conditions set forth above, the conversion privilege shall be available:
 - a. To a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death; and
 - b. To the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.
- B. If the group policy terminates or is amended so as to terminate the insurance of any class of Insured Persons, every Insured Person there under at the date of termination whose insurance terminates, including the insured dependent of an Insured Person, and who has been so insured for at least five (5) years prior to the termination date, shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by Subsection A above, except that the amount of the individual policy shall not exceed the smaller of:

1. The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one (31) days after termination; or
 2. \$10,000.
- C. If an Insured Person, or the insured dependent of an Insured Person, dies during the period within which the individual would have been entitled to have an individual policy issued in accordance with Subsection A or B above and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued under the individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

SECTION 4 - EXCLUSIONS AND LIMITATIONS

This insurance excludes loss, damage, cost or expense of any nature directly or indirectly caused by, resulting from or in connection with the following, regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

1. **War or warlike operations** (whether war be declared or not).
2. **Terrorist Activity**, including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity, in which the covered person participated and committed to supporting.
3. Active participation in **a war or in warlike operations**.
4. **Ionizing radiations** or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
5. **Suicide, attempted suicide** and intentionally self-inflicted injuries, whether sane or insane, gross negligence and violation of the law.
6. **Abuse of drugs, alcohol and medication** other than prescribed by a physician.
7. The Insured's **deliberate exposure to exceptional danger** (except in an attempt to save human life).
8. The Insured's own **criminal act**.
9. Any loss caused directly or indirectly from **extortion, kidnap & ransom** or wrongful detention of the Insured or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Insured is traveling.
10. Benefits will not be paid under this Policy, if the bodily injury occurs, either directly or indirectly, voluntarily or involuntarily, from any regularly and/or **extensively practiced hazardous sports**, including but not limited to; boxing, climbing/mountaineering requiring ropes or guides or free-climbing; flying except as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees; all professional sports; hang-gliding, delta-wing-gliding and paragliding; motorized racing of any form; deep sea diving; parachuting; bungee jumping; show jumping, steeple chasing, eventing or flat racing with a horse.

SECTION 5 – TERMINATION

- A. Except as otherwise provided for under this Certificate, coverage will cease on the earliest of the following to occur:
1. the date the Group Policy terminates;
 2. the date You cease to be an Eligible Employee;
 3. if premium is not paid when required, the last day of the period for which premium was paid;
 4. [for AD&D coverage, the earlier of the date Your corresponding life insurance ends, the date you are no longer Actively at Work, the date Your Waiver of Premium Benefit begins.]
 5. [for Dependent coverage, the date a Dependent is no longer eligible for Dependent coverage.]
- B. Approved FMLA Leave of Absence
 With regard to the Federal Family and Medical Leave Act (FMLA) of 1993, as amended, the Employer and Employee must be eligible for FMLA in order to receive it. If You are on an approved FMLA leave, coverage will continue until the later of the leave period required by FMLA or the leave period required by applicable state law, provided that:

1. We receive written notice in advance of a leave approved by the Employer which includes the beginning and ending dates of the leave; and
2. FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
3. the Employer remits the required premium for coverage.

C. Termination or Amendment of the Group Policy

1. The Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of the Group Policy. Any such change or amendment may apply to current eligible persons covered under the Group Policy or to any separate classes or categories thereof.
2. We may change the Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or (ii) with the Policyholder's or Employer's consent.
3. We may terminate an Employer's coverage on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.
4. Benefits are limited to the terms of the Group Policy, including any valid amendments. No change or amendment of the Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to the Policyholder. The Policyholder and their Eligible Employees or representatives have no right or authority to change or amend the Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

D. [Leave of Absence

- a. Coverage will continue as the result of an Illness or Injury provided that:
 - (1) We receive written notice in advance of a leave of absence approved by the Employer which includes the beginning and ending dates of the leave; and
 - (2) leaves of absence and the right to continue coverage during a leave of absence are available to all Employees in the same Eligible Class under the Group Policy; and
 - (3) You continue to pay the required premium, if any, to the Employer without interruption and the Employer continues to remit premium to Us on Your behalf.
- b. Unless You return to active, eligible status on or before the date the leave of absence is scheduled to end, coverage extended during a leave of absence will terminate on the earlier of:
 - (4) the date the leave of absence is scheduled to end;
 - (5) [1-60] months from the date the leave of absence began; or
 - (6) the date You fail to pay the premium as required.

This Leave of Absence provision is subject to undertaking no hazardous / dangerous pursuits, or being in locations that are regarded as war zones, or locations with active hostilities occurring.]

SECTION 6 - PREMIUM PAYMENT

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium from the Policyholder, which must be made payable to the Company. Payment must be in the currency approved by the Company, and is due on or before the Premium Payment Date based on the Premium Payment Mode shown on the Policyholder application. Any other forms of currency shall not be accepted and will be considered as non-payment of Premium unless otherwise agreed to in writing by the Company.

Grace Period

A grace period of 31 days, without interest charge, will be allowed for payment of any premium due after the first premium. The Company will suspend coverage during the specified period if Premium is not received by the Premium Payment Date from the Policyholder. If Premium is received within 31 days from the Premium Payment Date, coverage will resume without interruption in coverage. If the Premium due is not paid within the grace period, the Group Policy will end automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period.

SECTION 7 – BENEFICIARY AND CLAIMS PROVISIONS

Beneficiary

The designation of a beneficiary in the Policy or in any declaration in writing by the Insured shall create a trust in favor of the beneficiary for the proceeds of the Policy, if and when the proceeds of the Policy become payable upon the death of the Insured. Beneficiaries may be in two classes; primary or secondary (contingent). Beneficiaries in the same class will share equally in any Death Benefit payable to them, unless a designation from the Insured states otherwise. The nomination of a Beneficiary will fail if any of the following circumstances occur.

- If the Beneficiary predeceases the Insured, or
- Through failure of the Insured to notify the Insurer of any reappointment of a Beneficiary following the cancellation of an assignment, or
- Through failure of the Insured to notify the Insurer of any changes to the designation or appointment of Beneficiaries.

The Death Benefit will be paid to:

- Any primary Beneficiaries who are alive when the Insured dies, or
 - If no primary Beneficiary is then alive, to any secondary (contingent) beneficiaries who are then alive, or
- If no designated Beneficiary is then alive when the Insured dies, the Insured's estate will be the Beneficiary.

A. Filing A Claim

1. To file a claim for benefits under this Certificate, the claimant (depending on the benefit the claimant could be an Insured Person, a beneficiary or personal representative of an Insured Person) must provide Us with Proof of Loss in a timely manner. Or, upon receipt of written notice of claim, We will send the claimant a Claim Form for filing Proof of Loss. If the claimant does not receive such forms within 15 days after the giving of such notice, the claimant can send us, without the Claim Form, the written proof covering the occurrence.
2. Proof of Loss.
 - a. Proof of Loss must be provided in writing to Us, at the claimant's expense, within 90 days after the date of the loss if reasonably possible. If that is not reasonably possible, Proof of Loss must be provided no later than one year after expiration of that 90-day period, or the claim will be denied. The time limits under this section shall not apply while the claimant lacks legal capacity.
 - b. **Proof of Loss** means satisfactory written proof that a loss occurred for which the Group Policy provides benefits, which is not subject to any exclusion, and which meets all other conditions for benefits. Proof of Loss includes any other information We may reasonably require in support of a claim for benefits under the Group Policy.

B. Notice of Decision on Claim

1. We will evaluate a claim for benefits promptly after We receive it. Within 30 days after We receive the claim We will send the claimant:
 - a. a written decision on the claim; or
 - b. a notice that We are extending the period to decide the claim for an additional 45 days.
2. If the claim is approved, We will pay benefits within 30 days after the Proof of Loss requirement is satisfied.
3. If We extend the period to decide the claim, We will notify the claimant of the following:
 - a. the reasons for the extension;
 - b. when We expect to decide the claim; and
 - c. any additional information We require to decide the claim.
4. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may decide the claim based on the information We have received.
5. If We deny any part of the claim, We will send the claimant a written notice of denial containing:
 - a. the reasons for Our decision;
 - b. reference to the parts of the Group Policy on which Our decision is based;
 - c. a description of any additional information required to support the claim;
 - d. information concerning the claimant's right to a review of Our decision.

C. Payment of Claims.

Upon receipt of proper Proof of Loss, benefits will be paid within 30 days. If any claims payment interest accrues, interest will be paid in the amount determined by the State in which the claims are incurred.

Death Claims: If an Insured Person dies while insured for life insurance under the Group Policy, We will pay benefits according to the "Schedule of Benefits", after We receive Proof of Loss, as follows.

1. The death benefit will be paid in a single sum or by any other method agreeable to Us and the beneficiary. Payment of the benefit will extinguish Our liability under the Group Policy for which the death benefit has been paid.
2. No Surviving Beneficiary. If You do not name a beneficiary, or if You are not survived by any named beneficiary, benefits will be paid to Your estate.
3. Dependent Benefits. Dependent Life Insurance benefits that are payable, but unpaid at the Insured Person's death, will be paid in equal shares to the first surviving class of the following, if the Eligible Employee is dead:
 - a. The children of the Dependent.
 - b. The parents of the Dependent.
 - c. The Insured Person's estate.
4. Facility of Payment. If the benefits provided by the Group Policy are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to \$500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

D. Review Procedure.

1. If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.
2. The claimant may send Us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.
3. We will review the claim promptly after We receive the request. Within 60 days after We receive the request for review We will send the claimant:
 - a. a written decision on review; or
 - b. a notice that We are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.
4. If We extend the review period, We will notify the claimant of the following:
 - a. the reasons for the extension;
 - b. when We expect to decide the claim on review; and
 - c. any additional information We require to decide the claim.
5. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may conclude Our review of the claim based on the information We have received.
6. If We deny any part of the claim on review, the claimant will receive a written notice of denial containing:
 - a. the reasons for Our decision.
 - b. references to the provisions of the Group Policy on which Our decision is based.
 - c. information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

The Group Policy does not provide voluntary alternative dispute resolution options.

SECTION 8 - GENERAL PROVISIONS

Entire Contract and Changes

This Certificate, the Policy, the Policyholder application, any amendments, endorsements or riders, and the enrollment forms including health questionnaires (if any) of the Insured persons, make up the entire Contract between the parties.

No change may be made to this Certificate or the Policy unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Policy Endorsement/Rider signed by an Officer of the Insurer, or an

amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change the Entire Contract or waive any of its provisions.

Incontestability of Insurance

1. Any statement made to obtain or to increase insurance is a representation and not a warranty.
2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless:
 - a. the insurance would not have been approved if We had known the truth; and
 - b. We have given You or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.
3. After insurance has been in effect for 2 years, during the lifetime of the Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

Incontestability of the Group Policy or Employer Coverage under the Group Policy

1. No misrepresentation by the Policyholder will be used as a basis for denying a claim, or for denying the validity of the Group Policy unless:
 - a. the Group Policy would not have been issued if We had known the truth; and
 - [b. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.]
2. The validity of the Group Policy will not be contested after it has been in force for 2 years, except for nonpayment of premium or fraudulent misrepresentations.

Misstatement

If the age or gender, or both, of a person has been misstated, We will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:

1. the amount of insurance based on the correct age and gender; and
2. the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

Simultaneous Death Provision.

If a beneficiary dies on the same day You die, or within 120 hours from Your time of death, benefits will be paid as if that beneficiary had died before You, unless Proof of Loss with respect to Your death is delivered to Us before the date of the beneficiary's death.

Clerical Error

1. Clerical error by Us, the Policyholder, Your Employer, or their respective Eligible Employees or representatives will not:
 - a. cause a person to become insured under the Group Policy or a provision of it.
 - b. invalidate insurance otherwise validly in force.
 - c. continue insurance otherwise validly terminated.
 - d. cause an Employer to obtain coverage under the Group Policy or a provision of it.
2. In the event that a clerical error results in an incorrect rate, We reserve the right to adjust the rate accordingly.
3. The payment of premium, by itself, will not obligate Us to provide benefits to anyone who is not eligible for coverage under the Group Policy.

Your Employer acts on its own behalf as Your agent, and not as Our agent. Your Employer has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

Legal Actions

A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Assignment

An Insured may not assign any of his or her rights, privileges or benefits under the Group Policy, unless approved by Us.

Conformity With State Laws

If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

SECTION 9 – DEFINITIONS

Activities of Daily Living (ADL): Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication and transferring (getting in and out of bed).

Actively at Work: Working at your usual location as assigned by the Employer and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of sustained Active Work on those days.

Active participant: An active member of the military forces e.g. Army, Navy, Air Force, Territorial Army or Police or any other special forces activated by Government or other public authorities to defend law and order in case of a warlike operation, or any other person who takes up arms in an active or defensive role.

Annual Salary: Annual salary as used anywhere in this Policy means the basic salary (excluding any allowances and bonuses, unless otherwise agreed), currently being paid to an Insured Person on the last day of being actively at work preceding any illness, bodily injury, debility or other eventuality covered by the terms of this Policy.

Biological agent: Any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

Chemical agent: Any compound that, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

Contribution: the amount the Policyholder may require the Employee to pay towards the total premium.

Contributory: Insurance for which the Policyholder requires the Employee to pay all or any part of the premium.

Country of Residence: Where the Insured resides the majority of any calendar or policy year, or where the Insured has resided more than 180 days during any 12-month period while the Policy is in effect.

Deferred period: This is the time between the beginning of a disability and the time when disability payments may commence.

Eligible Employee: An employee of the Policyholder that meets all of the Eligibility criteria under this Policy.

Eligibility: The requirements that an Insured, including the primary Insured person and/or his dependent's must meet at all times in order to be covered under the this Employer Group Contract (See Eligibility and Conditions of Coverage Section).

Evidence of Insurability:

1. Providing Evidence of Insurability means that a person applying for coverage under the Group Policy must:
 - a. complete and sign Our Evidence of Insurability application and return the original application to Us. The application must be received by Us no later than [30/60] days from the date of signing; and
 - b. authorize Us to obtain information about the applicant's health; and
 - c. undergo a physical examination, if required by Us, which may include diagnostic testing; and
 - d. provide any additional information about the applicant's insurability that We may reasonably require.
2. If any applicant is required to provide Evidence of Insurability, the applicant will be responsible for all costs associated with providing Evidence of Insurability.

3. In each case where Evidence of Insurability is required, We base Our decision whether to approve coverage on the information provided during the underwriting process. If We learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, We may retroactively rescind coverage and deny claims.

Guarantee Issue: The amount of coverage provided which is not subject to Evidence of Insurability.

Expatriate: A person who works and resides outside of their Home Country, and is employed by the Employer.

HIV: All diseases caused by and/or related to the HIV Virus including Acquired Immune Deficiency Syndrome (AIDS).

Home Country: The country from which the Insured Employee holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the home country.

Inpatriate: A person who is a non-U.S. citizen who has been transferred to work and reside in the Home Country of the Employer (U.S.).

Local National: A person who resides and is employed in the country where he or she is a citizen, and is employed by the Employer.

Loss of a Limb: Permanent loss by physical separation of a hand at or above the wrist or of a foot at or above the ankle and includes permanent total and irrecoverable loss of use of hand, arm or leg.

Non-contributory: Insurance for which the Policyholder pays the entire premium.

Own Occupation: The insured is totally unable to perform the essential duties of their own previous occupation.

Permanent Total Disablement: Disablement which entirely prevents the Insured from attending to any business or occupation for which they are reasonably suited by training, education, or experience and which lasts 12 months and at the end of that period is beyond hope of improvement.

Policy Effective Date: The date that this Policy is first implemented, without regard to renewals thereafter.

Policyholder: An employer or other group that: a) has applied for coverage and is named as the Policyholder on the Policy Face Page of this Policy; and b) is providing a group insurance plan for its Employees or participants under this Policy.

Premium(s): The consideration owed by the Policyholder to the Insurer in order to secure benefits for its Eligible Employees under this Policy.

Premium Payment Mode: The recurring cycle specified in the application upon which the Premium for this Policy is due.

Terrorism: An act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear for such purposes.

Warlike operations: Hostilities; invasion; mutiny; riot; civil commotion assuming the proportions of or amounting to an uprising; civil war; rebellion; revolution; insurrection; conspiracy; military or usurped power; martial law or state of siege; act of an enemy foreign to the nationality of the Insured Person or the country in or over which the act occurs; overthrow of the legally constituted government; explosions of war weapons; murder or assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Assured whether war be declared with that state or not.

Administered by
[Name of Administrator]

[Major Medical Insurance
underwritten by
Independence American Insurance
Company]

[[Life/AD&D] [and Disability] Insurance
underwritten by
Madison National Life Insurance Company Inc.]

APPLICATION FOR GROUP INSURANCE COVERAGE Employer Plan

Proposed Effective
Date:

(dd/mm/yyyy)

Section 1: EMPLOYER INFORMATION

Employer Name: [] _____
Physical Address: [] _____
Street Address: [] _____ Country: [] _____ State/Province: [] _____
County/Region: [] _____ City: [] _____ Postal Code: [] _____
Mailing Address: Same As above Different from above (please provide in section 8).
Insurance Contact: [] _____
Email: [] _____ Fax: [] _____ Tel: [] _____
Position: [] _____ Preferred Method of Communication: email phone

Section 2: BUSINESS INFORMATION

Nature of Business: [] _____
No. of Years in Operation: [] Tax ID #: []
Type of Business: Corporation Partnership Sole Proprietorship Non-Profit Organization
Membership: Eligibility Criteria - Definition of employees to be covered: (chose all that apply)
 U.S. Employees Expatriates Local Nationals Inpatriates
Minimum number of hours required: [] per week
Number of Employees in each class:

	ELIGIBLE	ENROLLING
Expatriates:	[]	[]
Local Nationals:	[]	[]
Inpatriates:	[]	[]
U.S Employees:	[]	[]

Employer contribution toward cost of coverage:

	[Medical	[Basic Life[/AD&D]	[Basic STD Disability	Basic LTD Disability
Employee:	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %
Dependent:	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %	<input type="checkbox"/> 100% <input type="checkbox"/> Other: [] %
		<input type="checkbox"/> Supplement Option]		

Buy Up Option]

Definition of dependents:

Spouse or Domestic Partner (same or opposite sex); Children: if less than [26 years of age] [, 19 years of age [(or [21] if full-time student)] for Life].

[Are all eligible **dependents** required to enroll in the **Major Medical** plan? Yes No – Please explain below]

[Are all eligible **dependents** required to enroll in the **Life[/Disability]** plan? Yes No – Please explain below]

[Are all eligible **employees** required to enroll in the **Major Medical** plan? Yes No – Please explain below]

[Are all eligible **employees** required to enroll in the **Life[/Disability]** plan? Yes No – Please explain below]

If No, Please explain: []

Do you offer other carrier's [health,] [life or disability] plans to your employees? Yes No

To assure coordination between this plan and any other coverage currently offered, please provide the following for the expiring plan of benefits (include for multiple carriers if applicable):

Carrier Name(s): []

Type of Coverage(s): []

Anticipated Termination Date(s): [] (dd/mm/yyyy)

Are all employees covered by Worker's Compensation to the extent provided by law?

Yes, all carrier names []

No, please explain []

[For Life/Disability: Are any participants who are enrolling in the Madison National Life Insurance Company, Inc. plan disabled or hospitalized, or are any active employees currently not working, disabled or hospitalized? Yes No]

[Are any COBRA participants who are enrolling in the Independence American Insurance Company plan disabled or hospitalized, or are any active employees currently not working, disabled or hospitalized? Yes No

Name of Cobra Administrator: []]

[Your group is subject to Federal Cobra, if you employed 20 or more employees during at least 50% of the working days in the previous calendar year. Note: The employer is solely responsible for all aspects of the administration of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) How many existing COBRA participants do you have? [] How many in eligibility period? []

By checking this box, I acknowledge that I do NOT want the Company or Administrator to act as my COBRA administrator.]

Section 3: RISK EVALUATION

In order to evaluate an application properly, the Company requires the Employer to answer the questions below. This form should be filled out by the person responsible for operation of the current benefit plan. Please answer each question to the best of your knowledge with respect to all eligible employees and dependents that you intend to have covered under this plan.

1. Are any eligible employees currently NOT working at the locations indicated and performing their normal work functions? Yes No

2. Are you aware of any eligible employee that will be taking a leave of absence (medical or for other reasons) during the next 12 months? Yes No

3. Are you aware of any employee or dependent who is currently hospitalized or has hospitalization or surgery pending or that has been advised that hospitalization or surgery is needed? Yes No

4. Are you aware of any employee or dependent that has incurred claims in excess of \$5,000 during the past 12 months, or will incur expenses of \$5,000 or more in the next 12 months? Yes No

If you answered "Yes" to any of the questions above, please provide additional information below.

Please attach additional sheets if necessary: []

Section 4: ELIGIBILITY / ENROLLMENT OPTIONS

[MAJOR MEDICAL] Date of Eligibility
Eligibility date for new employees: (Choose One): First day of the month following date of eligibility
 Waiting Period of: 0 days 30 days 60 days 90 days]

[LIFE/AD&D] Date of Eligibility
Eligibility date for new employees: (Choose One): First day of the month following date of eligibility
 Waiting Period of: 0 days 30 days 60 days 90 days]

[Disability] Date of Eligibility
Eligibility date for new employees: (Choose One): First day of the month following date of eligibility
 Waiting Period of: 0 days 30 days 60 days 90 days]

THE INITIAL ENROLLMENT PERIOD WILL BE FOR [THIRTY-ONE (31)] DAYS [WITH A [THIRTY-ONE (31)] DAY ANNUAL OPEN ENROLLMENT PERIOD THEREAFTER]

Premium Proration Options (Choose One): **Option 1: Rule of 15/30**
An employee who becomes effective on or before the 15th of the month will be billed an entire month's premium. Nothing is billed for the first partial month for an employee who becomes effective on or after the 16th of the month. When an employee's coverage terminates on or before the 15th of the month, no premium is due; if coverage terminates on or after the 16th of the month, an entire month's premium is due.
 Option 2: Daily Proration
Billed only for actual days insured during the month.

Section 5: COVERAGE SELECTED

[Medical Yes No] [Life insurance Yes No] [Long Term Disability Yes No]
[Dental Yes No] [Accident (AD&D) Yes No] [Short Term Disability Yes No]
[Vision Yes No] [Supplement Option Yes No] [Supplement Option Yes No]
Note: Please see attached proposal for benefit and rate details. Proposal Dated: [] (dd/mm/yyyy)

Section 6: ADMINISTRATIVE INSTRUCTIONS

Premium Payment Mode: [Annual] [Semi-Annual] [Quarterly] [Monthly]

[Note: An Administrative fee will be charged for all payment modes other than Annual]

Premium Payment Currency: US\$ [Euro € GB£ CAD\$ CNY ¥ Other: _____]

[Note: Premium payment and benefit payment will be in the same currency]

Courier Instructions: Delivery of Policy Documents:
 To Physical Address To Mailing Address e-mail only: _____

Premium Payment: I agree that the employer is responsible for making the proper premium payments depending upon mode of payment. I understand that the first premium payment is due as of the date coverage becomes effective; subsequent premiums are due on the first day of each succeeding month. I understand a grace period of (31) days is allowed for any premium due after the first premium, and if such premium is not paid before the expiration of the thirty-one (31) day grace period, coverage for all insured persons shall lapse as of the premium due date. Any negotiable premium checks received after the thirty-one day grace period will be refunded less any amounts due (if any) from previous periods. I understand that the employer has the right to cancel the Policy, but must give thirty-one (31) days advance written notice to do so. Oral notice is not sufficient. If the employer fails to give such written notice, I understand that the employer will remain liable for all premiums owed for time periods prior to the effective date of cancellation.

Section 7: EMPLOYMENT STATEMENT

1. The employer hereby applies for the coverage indicated and agrees to all the following:
 - (a) The employer warrants that all information on this application is true and complete and that the Company or Administrator may rely on this application in deciding whether to provide coverage. If the application is not complete or if the information provided is inconsistent with any request or proposal submitted to the Company or Administrator reserves the right to re-rate the premium associated with such coverage, or reject the application.
 - (b) Any material misstatement or omission of information on this application or additional forms will be considered as misrepresentation and may be the basis of later termination of coverage.
 - (c) Employer understands and agrees that no coverage will be effective until notified in writing by the Company or Administrator.
 - (d) Premium rates quoted and benefits proposed may be adjusted based on actual enrollment.
 - [(e) Employer agrees that the Company or Administrator may contact its employees for the purpose of underwriting this application for Life, AD&D and Disability Income coverage only. For Life, AD&D and Disability Income coverage only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the insurance policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.]
2. The employer understands that if they are unable to maintain the minimum employee participation under the employer for a minimum of six (6) consecutive months, then coverage may cease as of the annual renewal date of this coverage under the Policy. After the initial application participation requirements are met, the employer must maintain minimum participation requirements of [75%-85%] of eligible employees.
3. It is understood and agreed that no agent or broker of the Company or Administrator has the authority to modify this application, waive the answer to any question, or bind the Company in any way by seeking any promise or representation.
4. The continued accuracy of the data is the responsibility of the Employer and the undersigned, as the authorized signature for the Employer, and is aware of this obligation, and hereby agrees to ensure that the [accuracy of the Actively At Work Statement and the] supplied personal data records is maintained.
5. I acknowledge I am advised not to terminate any existing coverage plans until I receive notification that this application has been approved by the Company.
[Fraud Notice: (see state fraud warning if applicable) OR SPECIFIC STATE FRAUD LANGUAGE WILL BE SHOWN HERE: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to civil and criminal penalties.]

Employer Signature: _____

Date: _____ (dd/mm/yyyy)

Title: _____

Section 8: SPECIAL ARRANGEMENTS / IMPORTANT NOTES:

[_____]

Section 9: PRODUCER INFORMATION (to be completed by producer or general agent)

Producer Name _____ Phone # _____ Fax # _____

Producer Address (P.O. Box not acceptable) _____

City _____ State _____ Zip _____

Producer e-mail _____ Producer Tax I.D. # _____

General Agent Tax I.D. # _____ Department of Insurance License # _____

General Agent Name _____ General Agent e-mail _____

Today's Date _____

Producer signature (required) _____

Print Name _____ [_____] _____

Is the insurance being applied for replacing any insurance now in force? Yes No

If Yes, please explain: [_____] _____

I certify to the best of my knowledge and belief that all responses given above are true and accurate and complete. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the employer and its employees. I have explained the pre-existing conditions limitation, the late enrollee extended pre-existing limitation for those Employees not applying at this time and the qualification of the effective date provisions for employees and dependents to this employer and its employees.

Administered by
[Name of Administrator]

[*[Life/AD&D] [and Disability] Insurance*
underwritten by
Madison National Life Insurance Company Inc.]

[ACTIVELY AT WORK STATEMENT]

This statement certifies that as of the proposed effective date, all employees who are eligible for insurance as described in this application are working the minimum number of hours required to be considered an Eligible Employee with the following exceptions.

Employee	Date of Birth	Last Day Worked	Return to Work Expected Date	Reason for Absence
[]	[]	[]	[]	[]

I understand that [Life and Disability] insurance coverage for the Employees listed above is not guaranteed without written acceptance by an authorized representative of Madison National Life Insurance Company, Inc.

[]

Printed Name of Authorized Employer Representative

[]

Title

Signature of Authorized Employer Representative

[]

Date

]

[State Specific Fraud Warnings

[Arkansas: 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.]

[California: For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

[Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard

to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

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

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

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

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

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

[Louisiana: 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.]

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

[Maryland: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.]

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

[New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[Nebraska: 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 may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20

[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.]

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

[Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Oregon: Any person who deceptively files a claim containing materially false information with an intent to knowingly defraud an insurer may have committed a crime.]

[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.]

[Tennessee: 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.]

[Virginia: 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.]

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

[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.]]

Administered by
[Name of Administrator]

[Major Medical Insurance
underwritten by
Independence American Insurance Company]

[[Life/AD&D] [and Disability] Insurance
underwritten by
Madison National Life Insurance Company Inc.]

Employee Enrollment Form / Evidence of Insurability Group Insurance Coverage

Form to be completed for:

- New Enrollees Late Enrollees – Reason for late enrollment: _____
 Change in Marital Status/Date _____ Add dependent(s)/Date _____
 Add Coverage _____ [Enrollees requesting amounts in excess of Guarantee Issue Maximums]
 Other _____ Date _____

Please print clearly and complete all applicable sections.

Section 1-A: Applicant Details						
[Last Name:	First Name:	Gender: Male Female	Height / Weight: m / feet: lbs / kgs:	Marital Status: Single / Married / Domestic Partner / Divorced / Widowed		
Date of Birth (dd/mm/yyyy):	Citizenship (If dual, provide both):	Passport # or National Identity Card #:		Nationality (Place of Birth):		
Date of Departure for International Assignment:	Country of Residence While on Assignment:			Anticipated Length of Assignment:		
Email Address:						
Employer Name:		Employer Address:				
Annual Salary (Specify Currency):		Occupation and Title (Please provide full description):				
Date of Hire (dd/mm/yyyy):		Number of Hours Worked per Week:]	
Section 1-B: Dependent Information – Complete this section if your Employer is offering Dependent Coverage and you are electing this coverage						
[Relationship:	Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: Male Female	Height / Weight: m / feet: lbs / kgs:	
Spouse						
Spouse's Occupation:			Spouse's Country of Residence:			
Relationship:	Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Child						
Relationship:	Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Child						
Relationship:	Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Child						
Relationship:	Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Child						
]						
[Section 1-C: Tobacco Usage						
Have you or any dependent applying for coverage used tobacco or discontinued the use of tobacco during the past [5 years]?						
<ul style="list-style-type: none"> • Proposed Employee: <input type="checkbox"/> No <input type="checkbox"/> Yes – indicate types of tobacco/cessation products and the frequency of usage: _____ • Additional Proposed Dependent: <input type="checkbox"/> No <input type="checkbox"/> Yes – indicate types of tobacco/cessation products and the frequency of usage: _____ 						
If discontinued, indicate the date stopped: Proposed Employee: _____ Additional Proposed Dependent: _____]						

Section 1-[D]: Coverage Elections - Please "✓" the applicable insurance coverage(s) you are electing [or waiving]

[[MAJOR MEDICAL] COVERAGE

Complete this section if your Employer is offering Major Medical coverage

<input type="checkbox"/> Employee <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Spouse <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> waiving coverage]
---	---	---

1. Have you and all dependents enrolling been covered by this employer's **major medical** plan for the past 12 months? Yes No
2. Have you and all dependents enrolling been covered under a **major medical** plan with another carrier(s) other than your current employer coverage within the past 12 months? Yes No If "Yes", attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage **AND** complete the following:

Name(s) of covered family member	Effective Date	Termination Date	Type of Coverage				
			Employer Group Coverage	Individual Medical	Government Sponsored	COBRA	Other
			<input type="checkbox"/>				
			<input type="checkbox"/>				

Prior medical carrier company name, phone number and policy number: _____]

[[DENTAL]/[VISION] COVERAGE

Complete this section if your Employer is offering [Dental]/[Vision] coverage

<input type="checkbox"/> Dental <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Employee <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Spouse <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> waiving coverage]
<input type="checkbox"/> Vision <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Employee <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Spouse <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> waiving coverage]

If applying for dental coverage, do you currently have employer group dental coverage? Yes No If "Yes", was coverage for orthodontia included? Yes No

Prior dental carrier company name, phone number and policy number: _____]

[SHORT TERM DISABILITY COVERAGE

Complete this section if your Employer is offering short term disability coverage

<input type="checkbox"/> Basic Short Term Disability [_____] <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Buy-up Short Term Disability [_____] <input type="checkbox"/> waiving coverage]
--	---

[LONG TERM DISABILITY COVERAGE

Complete this section if your Employer is offering long term disability coverage

<input type="checkbox"/> Basic Long Term Disability [_____] <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Buy-up Long Term Disability [_____] <input type="checkbox"/> waiving coverage]
---	--

[[LIFE]/[AD&D] COVERAGE

Complete this section if your Employer is offering [Life]/[AD&D] coverage

<input type="checkbox"/> Basic <input type="checkbox"/> Supplemental Life/[AD&D] – Employee [_____] <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Supplemental Life/[AD&D] – Dependent Spouse [_____] <input type="checkbox"/> waiving coverage]
<input type="checkbox"/> Supplemental Life/[AD&D] - Family [_____] <input type="checkbox"/> waiving coverage]	<input type="checkbox"/> Supplemental Life/[AD&D] – Dependent Child(ren) [_____] <input type="checkbox"/> waiving coverage]

[Section 1-[E]: Beneficiary Designation: If Primary Beneficiary(ies) is/are not living at the time of your death, benefits are to be paid to your secondary beneficiary. If you are married, a primary beneficiary designation of someone other than your spouse may not be effective under your state law. Please consult with your legal advisor before making such a designation.

Complete for Employee:

<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Name (Last, First, Middle)	Relationship:	Percent of Benefit: %
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Name (Last, First, Middle)	Relationship:	Percent of Benefit: %

Complete for Spouse

<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Name (Last, First, Middle)	Relationship:	Percent of Benefit: %
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Name (Last, First, Middle)	Relationship:	Percent of Benefit: %

Section 1-[F]: Travel Pattern

Anticipated travel pattern for the next 12 months. If applying for the War & Terrorism or Nuclear, Chemical, Biological perils extension, please provide details of security arrangements in place.

Destination	Frequency	Duration	Duties

[Section 2-A: Medical Questionnaire: Please complete if you are: [a new employee applying for coverage,] [applying for [Life/AD&D] [or Disability] coverage in excess of the guaranteed issue amount, or] [a late enrollee [for major medical]].

[1) Within the past 10 years, have you or any dependent applying for coverage been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following?	
1A) Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1B) Mental retardation; any mental, behavioral, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counseling or therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1C) High blood pressure; heart attack, stroke, chest pain or palpitations, murmur, varicose veins, blood clot, anemia, or any other blood heart, or circulatory disorder or condition? If yes, most recent blood pressure reading _____. Date recorded _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1D) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1E) Colitis; chronic diarrhea, or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1F) Cancer, tumor, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1G) Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1H) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1I) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1J) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1K) Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state Type _____ and most recent blood sugar reading _____. Date recorded _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1L) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1M) Alcoholism; alcohol, drug or substance abuse or dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1N) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Are you currently pregnant? Expected Due Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3A) If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3B) Is this pregnancy the result of infertility treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Have you been hospitalized in the last 10 years for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Do you engage in any profession, sport, or hobby that could be considered hazardous?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9) Do you receive any disability pension or work accident pension?	<input type="checkbox"/> Yes <input type="checkbox"/> No]

[Section 2-B: Medical Questionnaire: Give details of each item answered "Yes" in Section 2-A.

(If more space is needed, attach separate page, which must be signed and dated)

Name	Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates From/To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

[Section 2-C: Medication: List all medications that are currently prescribed for you or any dependent to be insured.

Name	Medication Name	Dosage	Frequency	Reason For Use

[Section 2-D: Medical Practitioner: Please provide details of your family Doctor, if you have one.

Name:	Mailing Address:	Phone Number:
-------	------------------	---------------

Section [3]: Representations, Acknowledgements, and Authorizations

Read the following information and signify your agreement with the terms of this Application for insurance by signing and dating as indicated below.

Application for Insurance: I understand that I am applying for insurance coverage under [separate major medical, life and disability] insurance contracts. The [major medical, life and disability] insurance hereby applied for will not be considered in force until a [major medical, life or disability] insurance certificate is issued, if coverage is approved provided that I meet all the eligibility requirements for the coverage I'm applying.

My Answers Are True and Correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all the questions asked. I understand that my intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents, if any. [However, I understand that my major medical coverage cannot be terminated or rescinded for health related factors.] I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Polic(ies).

Full-Time Employment: I understand that one of the requirements for initial eligibility and for continued eligibility under the plan is that I am employed full-time (usually at least [30 hours] per week) at my employer's place of business.

Premium Payment: I authorize my employer to deduct the requested premium contribution, if any, from my earnings.

Benefit Availability: I understand that my benefits under the Polic(ies) begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due premium has not been paid. I understand if I attempt to utilize the benefit plan [or prescription drug card] when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or insurance company for those services.

Preauthorization: I understand that failure to preauthorize treatment results in reduced benefits under the major medical policy pursuant to the terms of the Policy.

Pre-existing condition limitation provisions: I understand that the major medical health insurance coverage for each applicant will be subject to a pre-existing condition limitation. This exclusion period can be reduced by the number of days of your prior creditable coverage. To determine if any pre-existing condition limitation will apply to you, you must present your certificates or certificates of prior creditable coverage. Creditable coverage can include coverage under another group health plan, an individual health policy, short term health plans, student health plans, Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act. You may request a certificate of creditable coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a certificate of creditable coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. We will notify you only if, after considering the evidence, it has been determined the pre-existing condition exclusion period will still be imposed, in full or in part. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution, reinsurer or person that has any medical records or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to the Company or its authorized Administrator or legal representative (including medical review specialists). Any information obtained will not be released by the insurance company except to reinsurers, persons or organizations performing business or legal services in connection with my application or claim, including but not limited to pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. A photocopy of this authorization shall be valid as the original and is valid for [thirty (30)] months from the date shown below. Either my authorized representative or I may receive a copy of this authorization upon request.

[FRAUD WARNING (see state fraud warning if applicable) or State Specific Fraud Warning]

[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 may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

Signature of Employee

Date Signed

Check the box and sign and date below if you are waiving any insurance coverage for yourself or your dependents.

WAIVER OF COVERAGE. This is to certify that I have been given an opportunity to insure myself and/or my eligible dependents and I have **DECLINED** such coverage. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents in this plan, provided that I request enrollment within [thirty-one (31)] days of my other coverage ending. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption. If I choose to enroll myself or my dependents, at a later date, for a reason other than the special reasons stated herein, I understand that I and/or my dependents [may not enroll until my employer's next enrollment period][will be able to enroll as a late enrollee]. [I understand that I and/or my dependents will be subject to a pre-existing conditions limitation period which may be proportionately reduced by my furnishing certification or creditable coverage for myself and/or dependents.]

Signature of Employee (if declining any coverage)

Date Signed]

Fax completed application to [fax number] or Email to enroll@ABC.com]

[State Specific Fraud Warnings

[Arkansas: 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.]

[California: For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

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

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

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

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

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

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

[Louisiana: 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.]

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

[Maryland: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.]

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

[New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[Nebraska: 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 may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.]

[New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20

[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.]

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

[Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Oregon: Any person who deceptively files a claim containing materially false information with an intent to knowingly defraud an insurer may have committed a crime.]

[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.]

[Tennessee: 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.]

[Virginia: 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.]

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

[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.]]

SERFF Tracking #:

MADS-128830655

State Tracking #:

Company Tracking #:

GTL-GBG MNL

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L04G Group Life - Term/L04G.500 Other

Product Name:

Group Term Life - GBG

Project Name/Number:

GTL GBG MNL/GTL GBG MNL

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):	AR GA Notice 0110.pdf Readability - MNL cert, pol, INTL app, enroll.pdf AR CompNotice MNL 0210.pdf Certification.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	The application is new and is attached under the Form Schedule.		

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase certain life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract-holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a non-affiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

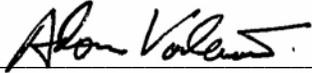
The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

CERTIFICATION OF FLESCH READING EASE SCORE

<u>Form Number (s)</u>	<u>Description</u>	<u>Score</u>
GTL-P-GBG-1112	Group Term Life/AD&D Master Policy	40.1
GTL-C-GBG-1112	Certificate of Coverage	48.0
INTL-MLD-APP-ER 0812	Employer Application Form	40.1
INTL-MLD-APP-EE 0812	Employee Enrollment Form	42.6

I hereby certify that the form(s) listed above meet(s) the minimum Flesch reading ease test score requirements of your state's simplified language law and/or regulation.



Adam C. Vandervoort
Secretary

Date 11/27/12

**Madison National Life Insurance Company, Inc.
Madison, Wisconsin**

PO Box 5008, Madison, Wisconsin 53705
1-800-356-9601

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

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

The name and address of your agent is as follows:

Certification

This is to certify that the forms included in this filing are in compliance with Rule 19, Unfair Sex Discrimination in the Sale of Insurance.



Adam Vandervoort
Secretary

January 9, 2013

Date

State: Arkansas
TOI/Sub-TOI: L04G Group Life - Term/L04G.500 Other
Product Name: Group Term Life - GBG
Project Name/Number: GTL GBG MNL/GTL GBG MNL

Filing Company: Madison National Life Insurance Company, Inc.

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/02/2013	Replaced 01/28/2013	Form	Group Term Life Master Policy	01/25/2013	GTL-P-GBG-1112.pdf (Superseded)
01/02/2013	Replaced 01/28/2013	Form	Group Term Life Certificate of Coverage	01/25/2013	GTL-C-GBG-1112.pdf (Superseded)
12/31/2012	Replaced 01/09/2013	Supporting Document	Flesch Certification	01/09/2013	AR GA Notice 0110.pdf Readability - MNL cert, pol, INTL app, enroll.pdf AR CompNotice MNL 0210.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Home Office: [1241 John Q. Hammons Drive, Madison, WI 53717]
Administrative Office: [26000 Towne Centre Drive, Foothill Ranch, CA 92610]
(Herein called We, Our, Us or the Company)

POLICYHOLDER: [ABC Company]
EFFECTIVE DATE: [September 1, 2012]
PREMIUM PAYMENT DATE: [monthly, quarterly, semi-annual, annually beginning [September 1, 2012]
RENEWAL DATE: Renewals occur [annually] beginning [September 1, 2012]
POLICY NUMBER: [] (herein called this Policy)
STATE OF DELIVERY: [State]
[ELIGIBLE EMPLOYEE CLASS: [Classes 1-4]]
[WAITING PERIOD: [30-90] days]
[ADMINISTRATOR: [Administrator Name]]
[RIDERS/ENDORSEMENTS: [Name of Rider]]
[ATTACHMENTS: [Policyholder Application, Certificate, Premium Rates]]
[CURRENCY: [US Dollars]]

Madison National Life Insurance Company, Inc. (hereafter called We, Our or Us) agrees to pay group insurance benefits with respect to each Insured Person according and subject to the terms and conditions of this Group Policy (hereafter referred to as Policy). Benefits are payable in United States dollars [or any other currency specifically agreed to in writing by Us]. The benefits and coverage provisions approved under this Policy are contained in the Certificate(s) of Insurance.

This Policy is issued to the Group Policyholder (hereafter referred to as "Policyholder") in consideration of the application and payment of premiums, as provided herein, to take effect as of the Effective Date. A copy of the completed Application is attached. All periods indicated herein shall be deemed to begin and end at 12:01 A.M. Standard Time at the address of the Policyholder. The first premium is due on the Effective Date and renewal premiums are due on the Premium Due Date shown above during the continuance of this Policy.

This Policy includes this page and all Endorsements, Riders, Schedule of Benefits, the Certificates, the Employers' group Application, the Employee Applications and any addendums. These pages are all part of this Policy as if fully recited over the signature shown below. This Policy is issued by Madison National Life Insurance Company, Inc. and delivered to the Policyholder in the state shown above and governed by the laws of the state of delivery. All benefits are provided in accordance with the terms, conditions and provisions of this Group Policy, including all Endorsements, if any, attached to this Group Policy, and applicable state laws. Terms specifically defined in this Policy are limited to that meaning only.

Madison National Life Insurance Company, Inc. has caused this Policy to be executed at its Home Office in Madison, Wisconsin on the Effective Date.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

GROUP [TERM LIFE] [ACCIDENTAL DEATH & DISMEMBERMENT] [TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT] INSURANCE POLICY

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding Us. An application for insurance or claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Group Policy and recovery of any amounts We have paid.

TABLE OF CONTENTS

DEFINITIONS2
CERTIFICATE OF COVERAGE2
EMPLOYER AS EMPLOYEE'S REPRESENTATIVE.....2
PARTICIPATION2
POLICY PREMIUM.....3
RENEWABILITY AND TERMINATION.....4
GENERAL PROVISIONS4
EMPLOYER RESPONSIBILITIES.....5

DEFINITIONS

All terms are as defined in the Certificate of Coverage.

CERTIFICATE OF COVERAGE

The Certificate of Coverage is incorporated into and made a part of this Policy.

The insurance Benefits and Coverage for an Employee are as selected and agreed upon between Us and the Policyholder. All Coverages and actual Benefit amounts in effect with respect to each Employee, and their Dependents, if any, will be as described in the individual Certificate issued by Us to or for that Eligible Employee which will include the Schedule of Benefits and any applicable Riders and Endorsements.

We will make available to each Eligible Employee a Certificate, including a Schedule of Benefits, and applicable Riders/Endorsements, if any, which generally describe, without amending, superseding or changing the Policy in any way, the essential features of coverage to which each Eligible Employee is entitled under this Policy. The Employer is solely responsible for the timely delivery of the Certificate including the Schedule of Benefits, and any applicable Riders/Endorsements, if any, to each of its Eligible Employees. The Employer acts as the agent for, and representative of, its Eligible Employee and their Dependents, if any, when receiving and/or distributing such documents to each Eligible Employee. Madison National Life Insurance Company, Inc. is not liable or responsible in any way whatsoever for any act, omission or statement by the Employer or its agent or representative in connection with this Policy or the delivery of any of these documents.

EMPLOYER AS EMPLOYEE'S REPRESENTATIVE

For any and all purposes regarding the Policy, including each Employee's coverage provided under the Policy, the Employer is neither the agent nor representative of Madison National Life Insurance Company, Inc. The Employer represents only itself and its Eligible Employees under this Policy; its employees, agents and representatives do not represent Madison National Life Insurance Company, Inc., employees, agents and representatives.

Madison National Life Insurance Company, Inc., agents and representatives are not liable or responsible in any way whatsoever for any act, omission or statement by the Employer, its Eligible Employees, Employees, agents or representatives.

PARTICIPATION

Eligibility for Participation: An Employer is eligible to maintain coverage under the Policy for the benefit of its Employees if it:

1. operates a viable business for 52 weeks each Calendar Year;
2. offers coverage to the Eligible Classes it determines on the Effective Date of Coverage;
3. offers coverage to persons eligible for and added to such Eligible Classes after the Effective Date of Coverage;
4. [meets or exceeds the minimum participation requirements; and
5. maintains the required contribution towards premium.]

Eligible Class: The Employer shall determine the Eligible Classes. The Eligible Classes elected by the Employer are shown on the Employer's Application.

An Eligible Employee may fall into one of the following Eligible Classes:

1. **[U.S. Employee]** refers to a person who works and resides in the United States and is employed by the Employer.]
2. **[Expatriate (Expat)]** refers to a person who works and resides outside of their Home Country and is employed by the Employer.]
3. **[Inpatriate]** refers to a non-U.S citizen who has been transferred to work and resides in the Home Country of the Employer.]
4. **[Local National (LN)]** refers to a person who works and resides in the country where he or she is a citizen and is employed by the Employer.]

An Eligible Employee whose Eligible Class is changed after the Effective Date of his coverage shall become eligible under another Eligible Class on the [first day of the month coinciding with or next following][date of eligibility] date specified by the Employer of the change.

Minimum Participation: The Company requires a minimum of [75-85%] participation of Employees of the Employer that are in the Eligible Classes defined under items 2 through 4 above.

POLICY PREMIUM

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium, which must be made payable to the Company. Payment must be in the currency approved by the Company, and is due on or before the Premium Payment Date shown on the Policy Face Page. Any other forms of currency shall not be accepted and will be considered as non-payment of Premium unless otherwise agreed by the Company.

Prior to each Premium Payment Date, the Company shall send to the Policyholder an invoice and shall also provide a listing of the Insured Employees. The Policyholder shall update such list with all changes, as well as identifying those Insured Employees who have terminated their employment with the Policyholder, and forward it to the Company together with the payment of the total Premium debit stated on or before the Premium Payment Date. If the list shows a Premium credit, the Company will credit the Policyholder, and apply such credit on the next billing cycle.

1. [The Policy and rates shall be guaranteed for [one year] and are continually subject to the terms in force at the time of each renewal date.]
2. All premiums are payable before coverage under this Policy is provided.

Grace Period: A grace period of 31 days, without interest charge, will be allowed for payment of any premium due after the first premium. The Company will suspend coverage during the specified period if Premium is not received by the Premium Payment Date. If Premium is received within 31 days from the Premium Payment Date, coverage will resume without interruption in coverage. If the Premium due is not paid within the grace period, the Company will cancel the Policy as of the date through which Premiums are paid.

If the Company receives written notice by the Policyholder of its intent to cancel the Policy, the Company will cancel the Policy on the later of the following:

1. The date requested by the Policyholder but no greater than 31 days from the date notice was received by the Company, or
2. The date the Company receives the notice.

All unpaid Premium through the date of cancellation is the obligation of the Policyholder and any other premium adjustments assessed as a result of cancellation. There will be a service fee for any checks returned for insufficient funds, closed accounts, or for stop payments on checks. Returned checks will be treated as non-payment of Premiums.

Policy and Rate Modifications

The Policy term begins on the Effective Date of the Policy as shown on the Policy Face Page and ends at midnight prior to the Renewal Date.

The Company has the right to change any Premium, or rate basis, on one of the following:

1. [Any Premium Payment Date: [The Policy and rates shall be guaranteed for one year and are continually subject to the terms in force at the time of each Renewal Date. After the first year, rates will not be changed more often than once every 6 months.] The Company must notify the Policyholder of the change in writing at least 31 days before the Company makes the change; or]
2. Any Renewal Date: The Company must notify the Policyholder of the change at least 31 days before the Company makes the change, or
3. At any time the demographics / location of the Policyholder or employees change.

Other Premium Changes

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:

1. Any mutually agreed upon change in benefits provided under the Policy;
2. Additions, deletions, increases or decreases of an Insured Employee's Dependent's insurance;
3. Addition of a new Insured;
4. Termination of an Insured;
5. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
6. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
7. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

Any such change will be prorated to the Premium payment period of the Policyholder and reflected on the Policyholder's next billing statement. Continued payment of the appropriate Premium (including payment at changed rates) shall be confirmation of the Insured's acceptance of the Policy or Premium change and will result in the continuation of coverage, as modified, without interruption.

Any other changes relating to Insured Employees (such as change of address or occupation) or of any other material changes that affect information given in connection with the application for coverage under this Policy must be disclosed.

RENEWABILITY AND TERMINATION

Renewability of Policy

The Policy automatically renews on the Renewal Date shown on the Policy face page, except for the following reasons:

1. Non-payment of premiums;
2. Fraud or misrepresentation of or by the Employer, or with respect to coverage of an Insured Person, fraud or misrepresentation by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the contribution and participation requirements;
4. For not maintaining Employee or Dependent participation or contributions requirements;
5. The Insurance Commissioner of the state in which the Employer originally obtained coverage finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
6. The Insurance Commissioner of the state in which the Employer originally obtained coverage finds that the continuation of coverage would impair Our ability to meet Our obligations;
7. The type of coverage under the Policy is no longer offered by Us in the state in which the Employer originally obtained coverage in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state; or

Time For Non-Renewal Of Policy

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

Upon Subscribing to the Policy

The Policyholder shall provide the Company with the following:

1. A complete census, including a list of Eligible Employees, and indicating for each person family name, first name, date of birth, family status, country of assignment, nationality (country of citizenship) and salary, if applicable, and job title,
2. A list of Employees unable to work on the Effective Date of the Policy, and reasons why,
3. Completed Enrollment Forms and any requested Health Questionnaires completed by each Employee. Completed, signed originals must be received within 30 days of the Effective Date of the Policy.

During the Term of the Policy

The Employer agrees to the following:

1. Enroll all new Eligible Employees on hire date as well as all other Employees who become eligible. When enrolling employees, the Policyholder will indicate either the hire date or the date when the employee became an Eligible Employee;
2. Inform the Company, of the name and date of termination of all Insured Employees and/or Insured Dependents that are no longer eligible for coverage under this Policy, within 31 days of the date of termination;
3. Submit a completed Enrollment Form for each Eligible Employee.

GENERAL PROVISIONS

Representations Not Warranties: Unless fraudulent, all statements made by, or for, an Eligible Person under this Policy are representations and not warranties. No statement can be used to void an Eligible Person's coverage unless a copy of the statement is signed by the Eligible Person and furnished to the Eligible Person or his or her beneficiary.

Incontestability: After an Employer's coverage has been in force two years from its effective date, no statement of the Employer will be used to void the Employer's coverage. No statement by any Eligible Person on a written application for insurance will be used to reduce or deny a claim after the Eligible Person's Coverage, with respect to which claim has been made, has been in effect for two years or more.

Clerical Error: If a clerical error is made so that an otherwise Insured Person's coverage does not become effective, coverage may be in effect if: (a) the Eligible Employee makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the Effective Date of coverage. The Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any premium refund will be reduced by any payment made for claims.

If claims paid exceed the premium refund or if benefits are paid to any person who Madison National Life Insurance Company, Inc. subsequently identifies as not being entitled to coverage under the Policy on the date a claim for benefit was incurred, the Employer will be liable for the amount of the benefits so paid. At Madison National Life Insurance Company Inc.'s option, it will bill the Employer for these amounts or adjust future premiums.

Reinstatement of Policy: If the Policy lapses due to non-payment of the required premiums, the Employer may reinstate the Policy, provided that within 20 calendar days immediately following the expiration of the 31-day Grace Period the Employer makes payment to Us or to Our Authorized Administrator of:

1. All premium remaining unpaid at the expiration of the Grace Period, and
2. The current month's due premium.

An Employer may reinstate the Policy once in any consecutive 24-month period and no Employer will have the privilege to reinstate the Policy more than once during any consecutive 24-month period.

In all other respects, We and the Employer will have the same rights under the Policy existing immediately before the due date of the non-payment of premium.

Non-Participation: This Policy is non-participating. It does not share in the Company's profits or surplus earnings.

Conformity With Laws: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Waiver Of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Electronic Exchange of Data: In the event the Employer and Company exchange data and information electronically, the Employer agrees to transfer on a timely basis all required data to the Company via electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Company, a copy of which shall be furnished to the Employer upon written request to the Company. The Employer authorizes the Company to submit such data and information in the specified electronic format. In the event the Employer is unable or unwilling to transfer data in the specified electronic format, the Company is under no obligation to receive or transmit data in any other format.

The Employer agrees to indemnify and hold harmless the Company from any and all liability arising out of the transfer of such data from the Employer to the Company or from the Company to the Employer. This indemnification also covers claims and or liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmission. If such transmissions occur, Company and the Employer agree to redirect the information via another mutually agreeable means.

EMPLOYER RESPONSIBILITIES

The Employer agrees:

1. To offer each Employee the opportunity to elect coverage under the Policy as a procedure of employment when he or she attains the status of an Employee as provided for in the Policy.
2. To furnish Madison National Life Insurance Company, Inc. or its authorized administrator on a monthly

basis and on Madison National Life Insurance Company, Inc. approved forms, such information as may reasonably be required by Madison National Life Insurance Company for the administration of coverage under the Policy, including any change in a Covered Person's eligibility status.

3. To comply with all policies and procedures established by Madison National Life Insurance Company, Inc. in administering and interpreting coverage under the Policy.
4. To furnish all enrollment and termination change notifications to Madison National Life Insurance Company, Inc. or its authorized administrator in a timely manner.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: [1241 John Q. Hammons Drive, Madison, WI 53717]
Administrative Office: [26000 Towne Centre Drive, Foothill Ranch, CA 92610]

[Trade Name]

Group [Life] [Accidental Death & Dismemberment] [Life and Accidental Death & Dismemberment] Insurance Certificate Of Coverage

VALIDATION OF COVERAGE

[Your certificate is validated by the attachment of this Validation of Coverage showing Your name and plan information.]

Policyholder	[ABC Company]
Group Policy Number:	[Policy No.]
Group Policy Effective Date:	[Date]
[Plan	[Plan Name]]
Employer Location:	[STATE]
[Insured Employee:	[As on file with the Administrator]
[Dependent Coverage:	[As on file with the Administrator]
[Employee Effective Date:	[As on file with the Administrator]
[Dependent Effective Date:	[As on file with the Administrator]
[Administrator:	[ABC Administrator]

The insurance coverage, benefits and the principal provisions that apply to the Insured Person [named above] are summarized in this Validation of Coverage, the Schedule of Benefits and the Certificate of Coverage and are merely evidence of insurance under the Policy. Insurance coverages are subject to the terms of the Policy, which alone constitutes the contract under which payment is made. The Policy is a contract between the Policyholder and Us. It may be changed or terminated only by those parties. Coverage is provided under Group Policy number shown above. Benefits are paid in United States Dollars or any other agreed upon currency specifically agreed to in writing by Us.

THIS FACE PAGE SUPERSEDES AND REPLACES ANY AND ALL
PREVIOUSLY ISSUED TO THE EMPLOYEE [NAMED ABOVE]

[THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S
COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER
YOUR EMPLOYER PARTICIPATES IN THE WORKER'S COMPENSATION SYSTEM AND HAS PURCHASED A
WORKER'S COMPENSATION INSURANCE POLICY.]

ANY PROVISION OF THE CERTIFICATE WHICH IS IN CONFLICT WITH FEDERAL LAWS OR ANY
APPLICABLE STATE LAW IS HEREBY AMENDED TO MEET THE MINIMUM REQUIREMENTS OF THE LAW.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



[Larry R. Graber
President



Adam C. Vandervoort
Secretary]

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding Us. An application for insurance or claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the Group Policy and recovery of any amounts We have paid.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	2
SECTION 1 - INTRODUCTION	4
SECTION 2 - ELIGIBILITY FOR INSURANCE, CONDITIONS OF COVERAGE AND EFFECTIVE DATES	4
SECTION 3 – BENEFITS	6
Group Term Life.....	6
Group Accidental Death & Dismemberment (AD&D).....	6
[Accident Permanent Total Disablement	6
[Waiver Of Premium	7
Conversion	9
SECTION 4 - EXCLUSIONS AND LIMITATIONS	10
SECTION 5 – TERMINATION	10
SECTION 6 - PREMIUM PAYMENT	11
SECTION 7 – BENEFICIARY AND CLAIMS PROVISIONS	12
SECTION 8 - GENERAL PROVISIONS.....	13
SECTION 9 – DEFINITIONS	15

SCHEDULE OF BENEFITS

A. Administrative

1. Policyholder:
2. Employer:
3. Plan Number:
4. Plan Effective Date:
5. Enrollment Period: [Annual/Open/Not Applicable] [Month Day, Year to Month Day, Year]
6. Eligible Class: Life Class [Number], [Description]
7. Minimum Hourly Work Requirement: [Number of hours] per [week/month/year]
8. Waiting Period for Insurance Coverage: [[0/30/60/90/180] days/as determined by the Employer]
9. Employee Premium Contribution:
 - Life/AD&D Coverage
 - Employee Basic: [1-100]%
 - [Employee Supplemental: [1-100]%]
 - [Dependent Basic – Family: [1-100]%]
 - [Dependent Basic – Spouse: [1-100]%]
 - [Dependent Basic – Child: [1-100]%]
 - [Dependent Supplemental: [1-100]%]
 - [Retiree: [1-100]%]
10. Insurance Reduction Schedule:
 - Life/AD&D Coverage
 - Employee Basic: [[0-95]% at Age [65-100]]
 - [Employee Supplemental: [[0-95]% at Age [65-100]]]
 - [Dependent Basic – Family: [[0-95]% at Age [65-100]]]
 - [Dependent Supplemental: [[0-95]% at Age [65-100]]]
 - [Retiree: [[0-95]% at Age [65-100]]]
11. Evidence of Insurability Requirements: Applies to Late Enrollees, Increases in Benefits and Amounts over Guarantee Issue Amounts, Reinstatement
12. Total Sum Insured [\$1 - \$750,000]

B. Life Insurance

- Employee Basic Life: [\$1-\$1,000,000]
- Guarantee Issue: [\$0-\$1,000,000]
- Maximum Issue: [\$1-\$1,000,000]

- [[Dependent Life
- [Family Basic Life: [\$100-\$50,000]
- Guarantee Issue: [\$0-\$50,000]
- Maximum Issue: [\$100-\$50,000]]

- [Spouse Basic Life: [\$1,000-\$500,000]
- Guarantee Issue: [\$0-\$500,000]
- Maximum Issue: [\$1,000-\$500,000]]

- [Child Life
- Age: Birth through 14 days: [\$0-\$50,000]
- Age: 15 days to 6 months: [\$100-\$50,000]
- Age: 6 months through the Age specified herein: [\$100-\$50,000]
- Guarantee Issue: [\$0-\$50,000]
- Maximum Issue: [\$0-\$50,000]]]

C. Supplemental Life Insurance

- Employee Supplemental Life: [\$1-\$1,000,000]
- Guarantee Issue: [\$0-\$1,000,000]
- Maximum Issue: [\$1-\$1,000,000]
- [Annual Increase in Coverage – Evidence of Insurability required if the benefit amount exceeds [[10-200]% of Annual Salary / [\$1,000-\$100,000]]

- [[Dependent Supplemental Life
- [Family Supplemental Life: [\$100-\$50,000]

Guarantee Issue:	[\$0-\$50,000]
Maximum Issue:	[\$100-\$50,000]]
[Spouse Supplemental Life:	[\$1,000-\$500,000]
Guarantee:	[\$0-\$500,000]
Maximum:	[\$1,000-\$500,000]]
[Child Supplemental Life	
Age: Birth through 14 day:	[\$0-\$50,000]
Age: 15 days to 6 months:	[\$100-\$50,000]
Age: 6 months through Limiting Age:	[\$100-\$50,000]
Guarantee Issue:	[\$0-\$50,000]
Maximum Issue:	[\$0-\$50,000]]]

D. Additional Benefits

- | | |
|-------------------------------------|-----------|
| 1. Conversion of Insurance Benefit: | Included |
| 2. [Waiver of Premium Benefit: | Included] |
| 3. [Living Benefit: | Included] |

[E. Accidental Death and Dismemberment

1. AD&D Insurance

<u>Employee AD&D:</u>	[\$1-\$1,000,000]
Guarantee Issue:	[\$0-\$1,000,000]
Maximum Issue:	[\$1-\$1,000,000]
<u>[[Dependent AD&D</u>	
Family AD&D:	[\$100-\$50,000]
Guarantee Issue:	[\$0-\$50,000]
Maximum Issue:	[\$100-\$50,000]]
[Spouse AD&D:	[\$1,000-\$500,000]
Guarantee:	[\$0-\$500,000]
Maximum:	[\$1,000-\$500,000]]

SECTION 1 - INTRODUCTION

This Certificate of Coverage is composed of 4 parts:

1. The Validation of Coverage;
2. The Schedule of Benefits;
3. The Certificate; and
4. Any Endorsements or Riders reflected in Your Schedule of Benefits and/or attached to this Certificate of Coverage.

This Certificate of Coverage describes Your eligibility and enrollment requirements, Your benefits, the exclusion and limitations applicable to Your benefits, and those things You need to do in order to be entitled to Your complete benefits. Specific definitions apply to this Certificate of Coverage. Please see the Definitions section of the Certificate of Coverage for definitions of specific terms.

SECTION 2 - ELIGIBILITY FOR INSURANCE, CONDITIONS OF COVERAGE AND EFFECTIVE DATES

ELIGIBILITY

All the employees of the Policyholder who are in an Eligible Class, meet the criteria indicated under Eligible Employees and have met any applicable Policyholder Waiting Periods are eligible for insurance. The Employer shall determine the Eligible Classes. The Eligible Classes elected by the Employer are shown on the Employer's Application, and the Schedule of Benefits.

Eligible Employees

Permanent, full-time Employees of the Employer, who satisfy the Minimum Work Requirement specified in the Schedule of Benefit for the Policyholder[, and are less than 70 years of age at time of enrollment.] [An Eligible Employee or dependent spouse may renew coverage up to age 75.]

[Insured Persons who are terminated from coverage during the Policy Year cannot be reactivated until the following Policy year.]

Eligible Dependents

Provided dependent coverage has been elected, coverage under the Policy can be extended to the following family members as Insured Dependents:

1. Spouse (Spouse includes Domestic Partner), and
2. Children up to age 19. Upon attainment of age 19, coverage will terminate at the end of the Policy Year.

Spouse means a person to whom the Employee is legally married, and not legally separated.

Domestic Partner means a person who lives in the same household and shares the common resources of life in a close, personal intimate relationship with the Eligible Employee provided that such individual would not be prevented from marrying the eligible employee due to age, blood relationship, or prior undissolved marriage to another. Except where otherwise specified, a Domestic Partner will herein be the equivalent of a Spouse.]

Dependent children include the Insured Employee's or the Insured Employee's Spouse's or Domestic Partner's natural children, legally adopted children, child placed for adoption, step children, child for whom the Insured Employee has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Insured Employee in a regular parent-child relationship.

Dependents are eligible for insurance on the later of: (a) the day the Insured Employee becomes eligible; or (b) the day the Insured Employee acquires the dependent. Dependents can only be insured if the Insured Employee is insured by the Policy and has elected Dependent coverage.

Residency

The residence of the primary insured and all dependents is assumed to be the work location assigned by the employer. If the spouse or dependents are living in another location, the Company must be notified in writing of

their full-time residence immediately. Further, it is assumed that the primary insured is residing in the work location assigned by the employer during the employment year. Any change must be immediately reported to the Company.

ENROLLMENT PROCEDURES

Conditions of Enrollment

An employee must be working the minimum number of hours specified in the Schedule of Benefits to be eligible. The employee must also meet the criteria under the section, Eligible Employees.

Coverage under the Policy that is provided on a Non-contributory basis is mandatory for all employees. All Eligible Employees are required to enroll under the plan up to the Guarantee Issue Amount. A waiver of coverage is not permitted. Any amounts of insurance that are Contributory, or in excess of the Guarantee Issue Amount are subject to Evidence of Insurability. Refer to the Schedule of Benefits for your options.

New Hired Employees

The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. Your initial date of eligibility is the first day of Your Waiting Period, which is typically the date on which employment begins. All new hired employees and Dependents added during the Policy Year must enroll within 31 days of the date of eligibility. The addition of such new Insured Persons may be subject to verification of hire date and employment status and/or any additional documents requested by the Company's Enrollment Department.

Employees who do not enroll within 31 days of the date of eligibility or on the Policy renewal date will be considered a Late Enrollee. (See Late Enrollee provision below).

Late Enrollee Eligibility (Employee or Dependent)

An Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period is a Late Enrollee.

Enrollment

If You or Your Eligible Dependent is entitled to enroll under the Policy during an Initial Enrollment Period, You must submit an Enrollment Form for Yourself and/or Your Dependent on or before the applicable enrollment deadline as described in this Certificate. You may obtain an Enrollment Form from Your Employer. The Enrollment Form must be received by Our designated administrator on or before the applicable enrollment deadline as described in this Certificate in order for You not to be considered a Late Enrollee.

Employee Effective Date

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date, after you have met any Employer defined Waiting Periods.
2. If You become eligible after the Employer's Effective Date and enroll during an Initial Enrollment Period, coverage will be effective the [first of the month] [date of eligibility] next following the later of the end of the applicable Waiting Period or receipt of the Enrollment Form by Us.
3. If You are applying for coverage in excess of the Guarantee Issue Amount, the coverage will be subject to Evidence of Insurability with such excess amount becoming effective the [first day of the month] [date of eligibility] next following the date on which We approve the application.

Dependent Effective Date

The Effective Date of a Dependent's coverage under the Policy, excluding a Late Enrollee, depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;
2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;
3. If the Dependent is a new spouse who first becomes eligible after Your Effective Date and You timely enroll the new spouse as described above, coverage will become effective as of the [first day of the month] [date of eligibility] next following the date on which We receive the Enrollment Form;
4. If the Dependent is a newborn Child who is born after the Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of birth;

5. If the Dependent is an adopted Child or a Child placed for adoption who is adopted or placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or placement for adoption; or
6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after the Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the [first day of the month] [date of eligibility] next following the date on which We receive the Enrollment Form.
7. If the Dependent is applying for coverage in excess of the Guarantee Issue Amount, the coverage will be subject to Evidence of Insurability with such excess amount becoming effective the [first day of the month] [date of eligibility] next following the date on which We approve the application.

SECTION 3 – BENEFITS

The Insurer provides group insurance coverage for eligible employees as designated by the Policyholder and agreed by the Insurer. **Refer to the Schedule of Benefits to determine the benefits purchased under the plan of insurance issued to the Policyholder.**

[Group Term Life: The group term life benefit becomes due in the event of the Insured Person's death while still covered under the Policy. The Insurer shall pay the full group term life benefit subject to any exclusions, limitations or coverage restrictions after receiving Proof of Loss. The Life insurance pays a benefit for death by illness or accident subject to all exclusions, limitations, terms and conditions of the Policy.]

[Group Accidental Death & Dismemberment (AD&D): Upon proof that the Insured Person has suffered any of the below outlined losses as a direct consequence of an accident within 360 days from the date of the accident, and provided that such loss is not the direct or indirect result of a risk excluded under the Policy, a benefit becomes payable in accordance with the provisions and limitations as set forth.

In case of dismemberment by accident the maximum benefit payable is as defined in the Schedule shown below. If a dismemberment benefit has been paid to an Insured Person who dies later, while still being covered under the Accidental Death & Dismemberment section, any dismemberment benefit already paid will be subtracted from the Accidental Death benefit should it become due.

Accident shall mean any bodily injury involuntarily sustained by the Insured Person as a consequence of a sudden and unpredictable intervention of external forces.]

AD&D Benefit	Percentage of Benefit
1. [Accidental Death]	[100%]
2. [Total and irrecoverable loss of sight of both eyes]	[100%]
3. [Total and irrecoverable loss of sight of one eye]	[50%]
4. [Loss of two limbs]	[100%]
5. [Loss of one limb]	[50%]
6. [Total and irrecoverable loss of sight of one eye and loss of one limb]	[100%]
7. [Accident Permanent Total Disablement]	[100%]

[One payment of 100% of the AD&D benefit shall exhaust the AD&D benefits per Insured Person. In event of Accidental Death the Policy will pay in addition to the Group Life sum insured (double indemnity).]

[Accident Permanent Total Disablement

Permanent Total Disablement is written on an accident only basis. If the Insured Person is covered by a Long Term Disability policy, this Policy will not pay a benefit in addition to the Long Term Disability benefit.

- This Policy contains a 12-month deferred period.
- Employees: Accident Permanent Total Disablement is defined by Own Occupation.

- Spouses and Dependent Children: Accident Permanent Total Disablement is defined by Activities of Daily Living.]

[Accumulation Limit

The term “accident event” as used herein shall be understood to mean all individual losses arising out of and directly occasioned by one sudden, unexpected unusual specific event occurring at an identifiable time and place. However, the duration and extent of any “accident event” so defined shall be limited to 72 hours and within a 10 mile radius for any “accident event” hereunder, and no individual loss which occurs outside such period and/or radius shall be included in that “accident event”. The Policyholder may choose the date and time when such period of consecutive hours commences and also the specific 10-mile radius determining an “accident event”.

If any event is of greater duration than the above period, the Policyholder may divide that event into two or more “accident events” provided that no two periods overlap and provided no period commences earlier than the date and time of the first recorded individual loss to the Policyholder arising out of the event.

The Accumulation Limit is an amount equal to the Total Sum Insured as shown on the Schedule of Benefits, but not to exceed \$[1-10,000,000.]]

[Waiver Of Premium

A. Waiver of Premium Definitions

1. **Elimination Period** means the period of 9 months beginning on the date You become Disabled.
2. **Life Insurance** under this Waiver of Premium Benefit means all of the Life Insurance, as listed in the Schedule of Benefits, in force under the Group Policy on the day before the day You become Disabled.
3. **Proof of Disability** means documented clinical findings that prove that You are Disabled.

B. Waiver of Premium does not apply to AD&D Insurance.

C. Your Life Insurance will be continued as provided for under this section without payment of premium, if all of the following conditions are met:

1. You become Disabled prior to age 60 while insured under the Group Policy;
2. You remain Disabled without interruption for the duration of the Elimination Period;
3. You provide Us with written notice of Your Disability within 30 days after the end of Your Elimination Period;
4. You provide Us with satisfactory written Proof of Disability within 3 months from the last day of the Elimination Period;
5. Your claim is approved by Us.

B. When the Waiver of Premium Benefit Begins. If You qualify and are approved for the Waiver of Premium Benefit, Your premium will be waived beginning on the first day of the month immediately following the end of Your Elimination Period.

C. When Waiver of Premium Ends. Waiver of Premium ends on the earliest to occur of the following:

1. The date You cease to be Disabled;
2. The 91st day following the date We mail to You a request for additional Proof of Disability with which You fail to comply;
3. The date You refuse to submit to a medical examination or to cooperate with Our chosen health care provider;
4. The date You refuse to submit to or undergo vocational rehabilitation (which determines employment opportunities, if any, for individuals with disabilities);
5. [The date at which You’ve resided outside of the United States of America, or one of its territories during any 6 consecutive months for which premium had been waived;]
6. The effective date of an individual life insurance policy issued to You under the “Life Insurance Conversion Benefit” section.
7. The premium due date immediately prior to Your 65th birthday;
8. The date You Retire, unless such Retirement is due to a Disability.

D. Premiums

1. Premium payment must continue until the later of the end of Your Elimination Period or the date Your claim for the Waiver of Premium Benefit is approved by Us.
2. If Your Waiver of Premium benefit terminates because You cease to be Disabled or You fail to submit to a medical exam or cooperate with the examiner, for coverage to continue, You must be an Eligible Employee and premiums must resume on the next premium due date, or You must continue coverage as provided for under the “Life Insurance Conversion Benefit” section.

- E. Amount of Insurance
 - 1. The amount of Life Insurance continued under the Waiver of Premium Benefit is the amount in effect on the day before You became Disabled, if you were Actively at Work.
 - 2. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before You became Disabled.
 - 3. Your Life Insurance amount will not increase while Your Life Insurance premiums are being waived.
- F. We will not waive premiums if Your Disability results from intentionally self-inflicted Injuries or Physical Diseases, while sane or insane, or from Your voluntary participation in an illegal activity.
- G. If You die during the Elimination Period and are otherwise eligible for the Waiver of Premium Benefit, the Elimination Period will not apply.
- H. We may require further Proof of Disability in intervals that are reasonable based on Your type of Disability.
- I. Investigation Of Claim

With respect to benefits that are claimed during an Insured Person's lifetime, We may require him or her to undergo examination at reasonable intervals, at Our expense. Any such examinations will be conducted by appropriate Physician of Our choice. We may deny or suspend benefits if You fail to attend an examination, or do not give full effort and cooperation to the examiner.]

[LIVING BENEFIT

Terminally Ill and **Terminal Illness** mean a medical condition that is expected to result in Your death within [6-24] months.

- A. If You become Terminally Ill while covered for life insurance under the Group Policy You may elect to receive the Living Benefit as provided for under this section.
- B. The Living Benefit will be an amount equal to [25-100%] of Your Employee Basic Life Insurance [plus Your Employee Supplemental Life Insurance] in effect on the date Your election is made, subject to a minimum of [\$5,000-50,000] and a maximum of [\$25,000-1,000,000]. The amount payable will be equal to the Living Benefit less applicable amounts, if any, charged for an investment loss (interest) and administrative fees.
- C. The payment will be made in one lump sum to You or to the payee You appropriately assign.
- D. The Living Benefit will not be available if:
 - 1. You have any portion of any Life Insurance or ownership rights thereof absolutely or irrevocably assigned or transferred;
 - 2. You have made an irrevocable beneficiary designation;
 - 3. the insurance proceeds are subject to a court order under a divorce decree, separate maintenance agreement or property settlement agreement;
 - 4. You have filed for bankruptcy, unless You give Us written approval from the bankruptcy court for payment of the Living Benefit; [and]
 - 5. [Your Terminal Illness resulted from an intentionally self-inflicted injury or suicide attempt within the first two years after Your effective date of coverage or an insurance increase].
- E. No payment will be made under this election unless and until We receive and approve of all of the following:
 - 1. Your signed and notarized election of this option on a form furnished by Us;
 - 1. signed and witnessed written statements of all irrevocable beneficiaries and assignees (and Spouse in marital property states) consenting to Your election of this option; and
 - 2. satisfactory written proof from a Physician other than Yourself or a member of Your or Your Spouse's immediate family that You have been diagnosed as being Terminally Ill and that You are of sound mind and under no constraint or undue influence.
- F. We may require a second opinion and examination of Your condition at Our own expense by a Physician of Our choice.
- G. Payment of the Living Benefit will reduce correspondingly the face amount of Your life insurance benefits under the Group Policy. This will result in reduced life insurance proceeds payable to Your beneficiary at Your death. Furthermore, any amount of insurance that would otherwise be continued [under the "Waiver of Premium

Benefit” section] will be reduced proportionately, as will the maximum face amount available under the “Life Insurance Conversion Benefit” section.

- H. Premium payments must continue to be paid for Your life insurance unless You qualify to have Your life insurance premium waived. [The premium payment due will not be affected by any Living Benefit paid under this provision.][The premium due will be based on the amount of insurance remaining in force after deducting the amount of the Living Benefit.]
- I. Payment of the Living Benefit will not affect the amount of, or change an existing beneficiary designation for, the AD&D Benefit, if any, in effect and kept in force under the Group Policy.
- J. Your election together with Our payment of the Living Benefit constitute a valid and effective beneficiary designation change, but only with respect to the specified life insurance benefits, and only to the extent affected by the Living Benefit payment, and applicable interest and fees, if any, charged thereon.
- J. Payment of the Living Benefit will be exempt from the claims of creditors and from legal process to the extent permitted by law.
- K. All other provisions of the Group Policy, including the effective date provisions of any benefit increases and the provisions on benefit reductions because of amendments to the plan or benefit classification changes or Your attained age, remain valid and in effect. Any such life insurance benefit reduction will be calculated based on Your life insurance amount in effect immediately before the Living Benefit payment.
- M. You are responsible for any tax consequences related to this benefit.]

Conversion

- A. If the insurance, or any portion of it, on an Insured Person covered under the Policy or on the dependent of an Insured Person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the Policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after termination and provided further that:
 - 1. The individual policy shall, at the option of such person, be on any one of the forms then customarily issued by the insurer (except for term insurance) at the age and for the amount applied for.
 - 2. The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of termination, less the amount of any life insurance for which the person becomes eligible under the same or any other group policy within thirty-one (31) days after termination, provided that any amount of insurance which shall have matured on or before the date of termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of termination; and
 - 3. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to the individual age attained on the effective date of the individual policy. Subject to the same conditions set forth above, the conversion privilege shall be available:
 - a. To a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death; and
 - b. To the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.
- B. If the group policy terminates or is amended so as to terminate the insurance of any class of Insured Persons, every Insured Person there under at the date of termination whose insurance terminates, including the insured dependent of an Insured Person, and who has been so insured for at least five (5) years prior to the termination date, shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by Subsection A above, except that the amount of the individual policy shall not exceed the smaller of:

1. The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one (31) days after termination; or
 2. \$10,000.
- C. If an Insured Person, or the insured dependent of an Insured Person, dies during the period within which the individual would have been entitled to have an individual policy issued in accordance with Subsection A or B above and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued under the individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

SECTION 4 - EXCLUSIONS AND LIMITATIONS

This insurance excludes loss, damage, cost or expense of any nature directly or indirectly caused by, resulting from or in connection with the following, regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

1. **War or warlike operations** (whether war be declared or not).
2. **Terrorist Activity**, including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity, in which the covered person participated and committed to supporting.
3. Active participation in **a war or in warlike operations**.
4. **Ionizing radiations** or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
5. **Suicide, attempted suicide** and intentionally self-inflicted injuries, whether sane or insane, gross negligence and violation of the law.
6. **Abuse of drugs, alcohol and medication** other than prescribed by a physician.
7. The Insured's **deliberate exposure to exceptional danger** (except in an attempt to save human life).
8. The Insured's own **criminal act**.
9. Any loss caused directly or indirectly from **extortion, kidnap & ransom** or wrongful detention of the Insured or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Insured is traveling.
10. Benefits will not be paid under this Policy, if the bodily injury occurs, either directly or indirectly, voluntarily or involuntarily, from any regularly and/or **extensively practiced hazardous sports**, including but not limited to; boxing, climbing/mountaineering requiring ropes or guides or free-climbing; flying except as a fare-paying passenger in a scheduled aircraft or in an employer owned or hired jet or helicopter for transportation of employees; all professional sports; hang-gliding, delta-wing-gliding and paragliding; motorized racing of any form; deep sea diving; parachuting; bungee jumping; show jumping, steeple chasing, eventing or flat racing with a horse.

SECTION 5 – TERMINATION

- A. Except as otherwise provided for under this Certificate, coverage will cease on the earliest of the following to occur:
1. the date the Group Policy terminates;
 2. the date You cease to be an Eligible Employee;
 3. if premium is not paid when required, the last day of the period for which premium was paid;
 4. for AD&D coverage, the earlier of the date Your corresponding life insurance ends, the date you are no longer Actively at Work, the date Your Waiver of Premium Benefit begins.
 5. for Dependent coverage, the date a Dependent is no longer eligible for Dependent coverage.
- B. Approved FMLA Leave of Absence
With regard to the Federal Family and Medical Leave Act (FMLA) of 1993, as amended, the Employer and Employee must be eligible for FMLA in order to receive it. If You are on an approved FMLA leave, coverage will continue until the later of the leave period required by FMLA or the leave period required by applicable state law, provided that:

1. We receive written notice in advance of a leave approved by the Employer which includes the beginning and ending dates of the leave; and
2. FMLA leaves of absence and the right to continue coverage during FMLA leaves are available to all Employees in the same Eligible Class under the Group Policy; and
3. the Employer remits the required premium for coverage.

C. Termination or Amendment of the Group Policy

1. The Group Policy may be terminated, changed or amended in whole or in part by Us or the Policyholder according to the terms of the Group Policy. Any such change or amendment may apply to current eligible persons covered under the Group Policy or to any separate classes or categories thereof.
2. We may change the Group Policy in whole or in part: (i) when any change or clarification in law or governmental regulation affects Our obligations under the Group Policy, or (ii) with the Policyholder's or Employer's consent.
3. We may terminate an Employer's coverage on any premium due date by giving the Employer not less than 60 days advance notice. An Employer may terminate coverage under the Group Policy in whole, and may terminate insurance for any class or group of eligible persons, at any time by giving Us advanced written notice at least 60 days prior to such termination. Insurance will terminate automatically for nonpayment of premium.
4. Benefits are limited to the terms of the Group Policy, including any valid amendments. No change or amendment of the Group Policy will be valid unless it is approved in writing by one of Our executive officers and delivered to the Policyholder. The Policyholder and their Eligible Employees or representatives have no right or authority to change or amend the Group Policy or to waive any terms or provisions thereof without Our signed, written approval.

D. [Leave of Absence

- a. Coverage will continue as the result of an Illness or Injury provided that:
 - (1) We receive written notice in advance of a leave of absence approved by the Employer which includes the beginning and ending dates of the leave; and
 - (2) leaves of absence and the right to continue coverage during a leave of absence are available to all Employees in the same Eligible Class under the Group Policy; and
 - (3) You continue to pay the required premium, if any, to the Employer without interruption and the Employer continues to remit premium to Us on Your behalf.
- b. Unless You return to active, eligible status on or before the date the leave of absence is scheduled to end, coverage extended during a leave of absence will terminate on the earlier of:
 - (4) the date the leave of absence is scheduled to end;
 - (5) [1-60] months from the date the leave of absence began; or
 - (6) the date You fail to pay the premium as required.

This Leave of Absence provision is subject to undertaking no hazardous / dangerous pursuits, or being in locations that are regarded as war zones, or locations with active hostilities occurring.]

SECTION 6 - PREMIUM PAYMENT

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium from the Policyholder, which must be made payable to the Company. Payment must be in the currency approved by the Company, and is due on or before the Premium Payment Date based on the Premium Payment Mode shown on the Policyholder application. Any other forms of currency shall not be accepted and will be considered as non-payment of Premium unless otherwise agreed to in writing by the Company.

Grace Period

A grace period of 31 days, without interest charge, will be allowed for payment of any premium due after the first premium. The Company will suspend coverage during the specified period if Premium is not received by the Premium Payment Date from the Policyholder. If Premium is received within 31 days from the Premium Payment Date, coverage will resume without interruption in coverage. If the Premium due is not paid within the grace period, the Company will cancel the Policy as of the date through which Premiums are paid.

SECTION 7 – BENEFICIARY AND CLAIMS PROVISIONS

Beneficiary

The designation of a beneficiary in the Policy or in any declaration in writing by the Insured shall create a trust in favor of the beneficiary for the proceeds of the Policy, if and when the proceeds of the Policy become payable upon the death of the Insured. Beneficiaries may be in two classes; primary or secondary (contingent). Beneficiaries in the same class will share equally in any Death Benefit payable to them, unless a designation from the Insured states otherwise. The nomination of a Beneficiary will fail if any of the following circumstances occur.

- If the Beneficiary predeceases the Insured, or
- Through failure of the Insured to notify the Insurer of any reappointment of a Beneficiary following the cancellation of an assignment, or
- Through failure of the Insured to notify the Insurer of any changes to the designation or appointment of Beneficiaries.

The Death Benefit will be paid to:

- Any primary Beneficiaries who are alive when the Insured dies, or
 - If no primary Beneficiary is then alive, to any secondary (contingent) beneficiaries who are then alive, or
- If no designated Beneficiary is then alive when the Insured dies, the Insured's estate will be the Beneficiary.

A. Filing A Claim

1. To file a claim for benefits under this Certificate, the claimant (depending on the benefit the claimant could be an Insured Person, a beneficiary or personal representative of an Insured Person) must provide Us with Proof of Loss in a timely manner. Or, upon receipt of written notice of claim, We will send the claimant a Claim Form for filing Proof of Loss. If the claimant does not receive such forms within 15 days after the giving of such notice, the claimant can send us, without the Claim Form, the written proof covering the occurrence.
2. Proof of Loss.
 - a. Proof of Loss must be provided in writing to Us, at the claimant's expense, within 90 days after the date of the loss if reasonably possible. If that is not reasonably possible, Proof of Loss must be provided no later than one year after expiration of that 90-day period, or the claim will be denied. The time limits under this section shall not apply while the claimant lacks legal capacity.
 - b. **Proof of Loss** means satisfactory written proof that a loss occurred for which the Group Policy provides benefits, which is not subject to any exclusion, and which meets all other conditions for benefits. Proof of Loss includes any other information We may reasonably require in support of a claim for benefits under the Group Policy.

B. Notice of Decision on Claim

1. We will evaluate a claim for benefits promptly after We receive it. Within 30 days after We receive the claim We will send the claimant:
 - a. a written decision on the claim; or
 - b. a notice that We are extending the period to decide the claim for an additional 45 days.
2. If the claim is approved, We will pay benefits within 30 days after the Proof of Loss requirement is satisfied.
3. If We extend the period to decide the claim, We will notify the claimant of the following:
 - a. the reasons for the extension;
 - b. when We expect to decide the claim; and
 - c. any additional information We require to decide the claim.
4. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may decide the claim based on the information We have received.
5. If We deny any part of the claim, We will send the claimant a written notice of denial containing:
 - a. the reasons for Our decision;
 - b. reference to the parts of the Group Policy on which Our decision is based;
 - c. a description of any additional information required to support the claim;
 - d. information concerning the claimant's right to a review of Our decision.

C. Payment of Claims.

Upon receipt of proper Proof of Loss, benefits will be paid within 30 days. If any claims payment interest accrues, interest will be paid in the amount determined by the State in which the claims are incurred.

Death Claims: If an Insured Person dies while insured for life insurance under the Group Policy, We will pay benefits according to the "Schedule of Benefits", after We receive Proof of Loss, as follows.

1. The death benefit will be paid in a single sum or by any other method agreeable to Us and the beneficiary. Payment of the benefit will extinguish Our liability under the Group Policy for which the death benefit has been paid.
2. No Surviving Beneficiary. If You do not name a beneficiary, or if You are not survived by any named beneficiary, benefits will be paid to Your estate.
3. Dependent Benefits. Dependent Life Insurance benefits that are payable, but unpaid at the Insured Person's death, will be paid in equal shares to the first surviving class of the following, if the Eligible Employee is dead:
 - a. The children of the Dependent.
 - b. The parents of the Dependent.
 - c. The Insured Person's estate.
4. Facility of Payment. If the benefits provided by the Group Policy are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to \$500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

D. Review Procedure.

1. If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.
2. The claimant may send Us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.
3. We will review the claim promptly after We receive the request. Within 60 days after We receive the request for review We will send the claimant:
 - a. a written decision on review; or
 - b. a notice that We are extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.
4. If We extend the review period, We will notify the claimant of the following:
 - a. the reasons for the extension;
 - b. when We expect to decide the claim on review; and
 - c. any additional information We require to decide the claim.
5. If We request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, We may conclude Our review of the claim based on the information We have received.
6. If We deny any part of the claim on review, the claimant will receive a written notice of denial containing:
 - a. the reasons for Our decision.
 - b. references to the provisions of the Group Policy on which Our decision is based.
 - c. information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

The Group Policy does not provide voluntary alternative dispute resolution options.

SECTION 8 - GENERAL PROVISIONS

Entire Contract and Changes

This Certificate, the Policy, the Policyholder application, any amendments, endorsements or riders, and the enrollment forms including health questionnaires (if any) of the Insured persons, make up the entire Contract between the parties.

No change may be made to this Certificate or the Policy unless it is approved by an Officer of the Insurer. A change will be valid only if made by a Policy Endorsement/Rider signed by an Officer of the Insurer, or an

amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change the Entire Contract or waive any of its provisions.

Incontestability of Insurance

1. Any statement made to obtain or to increase insurance is a representation and not a warranty.
2. No misrepresentation will be used as a basis for reducing or denying a claim or contesting the validity of insurance unless:
 - a. the insurance would not have been approved if We had known the truth; and
 - b. We have given You or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.
3. After insurance has been in effect for 2 years, during the lifetime of the Insured Person, We will not use a misrepresentation as a basis for reducing or denying a claim, unless it was a fraudulent misrepresentation.

Incontestability of the Group Policy or Employer Coverage under the Group Policy

1. No misrepresentation by the Policyholder will be used as a basis for denying a claim, or for denying the validity of the Group Policy unless:
 - a. the Group Policy would not have been issued if We had known the truth; and
 - [b. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.]
2. The validity of the Group Policy will not be contested after it has been in force for 2 years, except for nonpayment of premium or fraudulent misrepresentations.

Misstatement

If the age or gender, or both, of a person has been misstated, We will make an equitable adjustment of premiums, benefits or both. The adjustment will be based on:

1. the amount of insurance based on the correct age and gender; and
2. the difference between the premiums paid and the premiums which would have been paid if the age and gender had been correctly stated.

Facility of Payment

If the benefits provided by the Group Policy are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not legally competent to give a valid release, We may pay up to \$500 to any person related to the Insured Person by blood or marriage. Any payment made in good faith will fully release Us to the limit of the payment. If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will pay the life proceeds to the legally appointed guardian. The guardian must provide Us with adequate written proof of such appointment. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law. Payment made before We have received written notice at Our home office of a valid claim by some other person releases Us from further obligation.

Simultaneous Death Provision.

If a beneficiary dies on the same day You die, or within 120 hours from Your time of death, benefits will be paid as if that beneficiary had died before You, unless Proof of Loss with respect to Your death is delivered to Us before the date of the beneficiary's death.

Clerical Error

1. Clerical error by Us, the Policyholder, Your Employer, or their respective Eligible Employees or representatives will not:
 - a. cause a person to become insured under the Group Policy or a provision of it.
 - b. invalidate insurance otherwise validly in force.
 - c. continue insurance otherwise validly terminated.
 - d. cause an Employer to obtain coverage under the Group Policy or a provision of it.
2. In the event that a clerical error results in an incorrect rate, We reserve the right to adjust the rate accordingly.
3. The payment of premium, by itself, will not obligate Us to provide benefits to anyone who is not eligible for coverage under the Group Policy.

Your Employer acts on its own behalf as Your agent, and not as Our agent. Your Employer has no authority to alter, expand or extend Our liability or to waive, modify or compromise any defense or right We may have under the Group Policy.

Legal Actions

A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Assignment

An Insured may not assign any of his or her rights, privileges or benefits under the Group Policy, unless approved by Us.

Conformity With State Laws

If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

SECTION 9 – DEFINITIONS

Activities of Daily Living (ADL): Activities of daily living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication and transferring (getting in and out of bed).

Actively at Work: Working at your usual location as assigned by the Employer and satisfying the Minimum Hourly Work Requirement. Actively at Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of sustained Active Work on those days.

Active participant: An active member of the military forces e.g. Army, Navy, Air Force, Territorial Army or Police or any other special forces activated by Government or other public authorities to defend law and order in case of a warlike operation, or any other person who takes up arms in an active or defensive role.

Annual Salary: Annual salary as used anywhere in this Policy means the basic salary (excluding any allowances and bonuses, unless otherwise agreed), currently being paid to an Insured Person on the last day of being actively at work preceding any illness, bodily injury, debility or other eventuality covered by the terms of this Policy.

Biological agent: Any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

Chemical agent: Any compound that, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

Contribution: the amount the Policyholder may require the Employee to pay towards the total premium.

Contributory: Insurance for which the Policyholder requires the Employee to pay all or any part of the premium.

Country of Residence: Where the Insured resides the majority of any calendar or policy year, or where the Insured has resided more than 180 days during any 12-month period while the Policy is in effect.

Deferred period: This is the time between the beginning of a disability and the time when disability payments may commence.

Eligible Employee: An employee of the Policyholder that meets all of the Eligibility criteria under this Policy.

Eligibility: The requirements that an Insured, including the primary Insured person and/or his dependent's must meet at all times in order to be covered under the this Employer Group Contract (See Eligibility and Conditions of Coverage Section).

Evidence of Insurability:

1. Providing Evidence of Insurability means that a person applying for coverage under the Group Policy must:

- a. complete and sign Our Evidence of Insurability application and return the original application to Us. The application must be received by Us no later than [30/60] days from the date of signing; and
 - b. authorize Us to obtain information about the applicant's health; and
 - c. undergo a physical examination, if required by Us, which may include diagnostic testing; and
 - d. provide any additional information about the applicant's insurability that We may reasonably require.
2. If any applicant is required to provide Evidence of Insurability, the applicant will be responsible for all costs associated with providing Evidence of Insurability.
 3. In each case where Evidence of Insurability is required, We base Our decision whether to approve coverage on the information provided during the underwriting process. If We learn that the information relied on to approve coverage was incorrect, or that relevant information was omitted, We may retroactively rescind coverage and deny claims.

Guarantee Issue: The amount of coverage provided which is not subject to Evidence of Insurability.

Expatriate: A person who works and resides outside of their Home Country, and is employed by the Employer.

HIV: All diseases caused by and/or related to the HIV Virus including Acquired Immune Deficiency Syndrome (AIDS).

Home Country: The country from which the Insured Employee holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the home country.

Inpatriate: A person who is a non-U.S. citizen who has been transferred to work and reside in the Home Country of the Employer (U.S.).

Local National: A person who resides and is employed in the country where he or she is a citizen, and is employed by the Employer.

Loss of a Limb: Permanent loss by physical separation of a hand at or above the wrist or of a foot at or above the ankle and includes permanent total and irrecoverable loss of use of hand, arm or leg.

Non-contributory: Insurance for which the Policyholder pays the entire premium.

Own Occupation: The insured is totally unable to perform the essential duties of their own previous occupation.

Permanent Total Disablement: Disablement which entirely prevents the Insured from attending to any business or occupation for which they are reasonably suited by training, education, or experience and which lasts 12 months and at the end of that period is beyond hope of improvement.

Policy Effective Date: The date that this Policy is first implemented, without regard to renewals thereafter.

Policyholder: An employer or other group that: a) has applied for coverage and is named as the Policyholder on the Policy Face Page of this Policy; and b) is providing a group insurance plan for its Employees or participants under this Policy.

Premium(s): The consideration owed by the Policyholder to the Insurer in order to secure benefits for its Eligible Employees under this Policy.

Premium Payment Mode: The recurring cycle specified in the application upon which the Premium for this Policy is due.

Terrorism: An act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear for such purposes.

Warlike operations: Hostilities; invasion; mutiny; riot; civil commotion assuming the proportions of or amounting to an uprising; civil war; rebellion; revolution; insurrection; conspiracy; military or usurped power; martial law or state of siege; act of an enemy foreign to the nationality of the Insured Person or the country in or over which the act occurs; overthrow of the legally constituted government; explosions of war weapons; murder or assault

subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Assured whether war be declared with that state or not.