



**BlueCross BlueShield  
of Illinois**

# **Voluntary Term Life and AD&D Insurance**

**Employee Benefit Booklet**

**VILLAGE OF OAK LAWN**

**F012986-0001**

**Class 1-01**

# Dearborn Life Insurance Company

Administrative Office:  
701 E. 22nd Street  
Lombard IL 60148

(A stock life insurance company, herein called the "We" "Us" or "Our")

Principal Office:  
300 E. Randolph Street  
Chicago IL 60601

## Having issued Group Policy No. F012986-0001

(herein called the *Policy*)

to

**VILLAGE OF OAK LAWN**

(herein called the *Policyholder*)

## Group Insurance Certificate

CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, become insured and remain insured in accordance with the terms of the *Policy*. *Your* insurance is subject to all the definitions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This Certificate describes *Your* eligibility for benefits and the terms and provisions of the *Policy*. It replaces and cancels any other Certificate previously issued to *You* under the *Policy*.

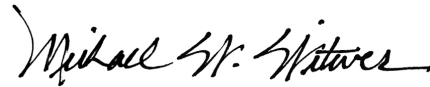
If the terms and provisions of the Group Insurance Certificate (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy*.

### READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company



Secretary



President

**Voluntary Group Term Life Insurance Certificate with Accidental Death & Dismemberment  
Dependent Life Insurance with Dependent Accidental Death and Dismemberment Benefits**

**Non-Participating**

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## ***SCHEDULE OF BENEFITS***

**POLICYHOLDER:** VILLAGE OF OAK LAWN  
**POLICY NUMBER:** F012986-0001  
**EFFECTIVE DATE:** October 1, 2014 - Revised Effective May 1, 2023  
**ANNUAL ENROLLMENT PERIOD:** 9/1-9/30

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**ELIGIBILITY: Class 01** All active full time Employees working a minimum of 37.5 hours per week of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 37.5 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

**Eligibility Waiting Period:** Current *Employees*: None  
New *Employees*: None

**Policyholder Contribution:** Voluntary Life & AD&D 0% of premium  
Dependent Life & AD&D 0% of premium

00001-SOB

### **GROUP TERM LIFE INSURANCE**

**Employee Voluntary Life Benefit Amount** Incremental selection from a minimum of \$10,000 to a maximum of \$250,000 in increments of \$10,000

Guarantee Issue Benefit Limit *Employee Voluntary*: \$50,000  
*Spouse Voluntary*: \$20,000

Amounts in excess of the Guarantee Issue Benefit Limit are subject to satisfactory *Evidence of Insurability*

*Voluntary*: Benefit amounts may be subject to Guarantee Issue limits based on participation levels as determined by *Us*. Any Guarantee Issue Limits established are only available during Your group's initial enrollment and for new employees who have met the Eligibility requirements. *Employees* must enroll within 31 days of their eligibility date to qualify for any established Guarantee Issue.

### **Reduction of Benefits**

*Voluntary* Group Term Life benefits reduce by 35% of the original amount at age 70 and further reduce to 55% of the original amount at age 75, 70% of the original amount at age 80, and 85% of the original amount at age 85. Benefits terminate at retirement.

*Dependent Spouse Voluntary* Group Term Life benefits reduce by 35% of the original amount at age 70 and further reduce to 55% of the original amount at age 75, 70% of the original amount at age 80, and 85% of the original amount at age 85. Benefits terminate at retirement.

### **Waiver of Premium**

Waiver Eligibility Totally Disabled prior to age 60 without interruption from the last date worked for at least 9 months

Insured Eligibility *Employee*

Maximum Waiver of Premium Duration Age 65

**Accelerated Death Benefit (ADB)**

Benefit Amount	50% of <i>Voluntary</i> Term Life Insurance In force
Insured Eligibility	<i>Employee</i>
Minimum Covered Life Insurance Amount	\$20,000
Maximum ADB Payment	\$100,000
Minimum ADB Payment	\$7,500

00002-SOB

**DEPENDENT TERM LIFE INSURANCE**

<i>Spouse</i> Benefit Amount	Voluntary: Incremental selection from a minimum of \$5,000 to a maximum of \$125,000 in increments of \$5,000, not to exceed 50% of Employee Amount.
Includes <i>Registered Domestic Partner</i>	
<i>Child(ren)</i> Benefit Amount	<i>Voluntary:</i> \$500 - Age live birth to 15 days \$500 - age 15 days to 6 months  Incremental selection from a minimum of \$1,000 to a maximum of \$10,000 in increments of \$1,000 - 6 months to 19 years (or 25 years if full time student)

**GROUP ACCIDENTAL DEATH & DISMEMBERMENT**

<b>Employee Voluntary AD&amp;D Coverage Amount</b>	Incremental selection from a minimum of \$25,000 to a maximum of \$500,000 in increments of \$25,000
<b>Dependent AD&amp;D Benefit Amount</b>	<i>Voluntary:</i>
<i>Spouse</i>	50% of the Employee Coverage Amount if no children are covered 40% of the Employee Coverage Amount if children are covered
<i>Dependent Child(ren)</i>	15% of the Employee Coverage Amount if no spouse is covered 10% of the Employee Coverage Amount if spouse is covered

<b>Reduction of Benefits</b>	<i>Voluntary</i> Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 70 and further reduce to 55% of the original amount at age 75, 70% of the original amount at age 80, and 85% of the original amount at age 85. Benefits terminate at retirement.  <i>Dependent Spouse Voluntary</i> Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 70 and further reduce to 55% of the original amount at age 75, 70% of the original amount at age 80, and 85% of the original amount at age 85. Benefits terminate at retirement.
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<b>Seat Belt Benefit</b>	10% of <i>Employee</i> Coverage Amount, to a maximum of \$25,000
<b>Air Bag Benefit</b>	5% of <i>Employee</i> Coverage Amount to a maximum of \$5,000
<b>Repatriation Benefit</b>	Actual costs to a maximum of \$5,000
<b>Education Benefit</b>	
Benefit Amount	3% of <i>Employee</i> Coverage Amount, to a maximum of \$3,000 per year
Maximum Benefit Duration	Benefit payable for a maximum of 4 Years
Eligible Dependents	Age live birth to age 19 years (23 if a full-time student)
<b>Day Care Benefit Amount</b>	
Benefit Amount	3% of <i>Employee</i> Coverage Amount to a maximum of \$5,000 per year

Maximum Benefit Duration	5 Years
<b>Maximum Spouse Training Benefit</b>	<b>\$5,000</b>

## ***ELIGIBILITY AND EFFECTIVE DATE PROVISIONS***

### ***Who is eligible for this insurance?***

The eligibility for this insurance is as indicated in the *Schedule of Benefits*.

The *Eligibility Waiting Period* is set forth in the *Schedule of Benefits*.

00001

### ***When does Your Contributory insurance become effective?***

***Contributory*** means *You* pay all or a portion of the premium for this insurance coverage.

*You* may apply for *Voluntary* insurance coverage during the *Annual Enrollment Period* as indicated in the *Schedule of Benefits*. *Your* coverage will become effective as follows, provided *You* are *Actively at Work* on that date:

*Your Contributory* coverage for amounts up to the Guarantee Issue Benefit Limit will become effective on the latest of the following dates provided *You* are *Actively at Work* on that date:

1. If *You* enroll for coverage prior to the *Policy* effective date and *Evidence of Insurability* is not required, the *Policy* effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for *Voluntary* coverage within 31 days after *Your* eligibility date, *You* must wait until the next *Annual Enrollment Period* to apply, unless *You* qualify because of a *Change in Family Status*.
  - a. Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment Period* will become effective on the *Policy* anniversary date.
  - b. Coverage requested within 31 days of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.

*You* must be *Actively at Work* for coverage under the *Policy* to become effective.

***Enrollment Form*** means the application *You* complete to apply for coverage under the *Policy*.

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### ***Change in Family Status***

If *You* experience a *Change in Family Status*, *You* may enroll for *Voluntary* coverage, apply for additional coverage, or request changes to *Your* current *Voluntary* benefit program(s) without providing *Evidence of Insurability*, provided the benefit change is consistent with the *Change in Family Status*. *You* must submit the appropriate *Enrollment Form* within 31 days of the *Change in Family Status*.

***Change in Family Status*** means changes in the status of *Your* family, including but not limited to:

1. *You* get married or execute a *Domestic Partner* affidavit;
2. *You* have a *Dependent Child*, or *You* adopt or become the legal guardian of a *Dependent* child;
3. *Your Spouse* dies or *You* become divorced;
4. *Your Dependent Child* becomes emancipated or dies;
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance, or;
6. *You* have a change in classification which results in *You* changing from part-time to full-time, or full-time to part-time.

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### ***When is Evidence of Insurability required?***

*Evidence of Insurability* is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date or *You* were eligible to enroll under the *Prior Policy* and did not enroll before the expiration of the time allowed to enroll; or
2. *You* voluntarily canceled *Your* insurance and choose to reapply; or
3. *Your* coverage amount exceeds the Guarantee Issue Benefit Limit as set forth in the *Schedule of Benefits*; or

4. *You* enroll for additional coverage that is greater than the next higher coverage option during an *Annual Enrollment Period*.

Receipt of premium before *We* have approved *Evidence of Insurability* will not constitute acceptance and does not guarantee issuance of any benefit amount prior to *Our* approval.

***Evidence of Insurability*** means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. *Evidence of Insurability* will be provided at *Our* expense if *You* enroll within 31 days after *Your* eligibility date. *Evidence of Insurability* will be provided at *Your* expense if *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date.

***Evidence of Insurability Form*** means a form provided or approved by *Us* on which *You* provide a statement of *Your* medical history.

*You* may obtain an *Evidence of Insurability Form* from the *Policyholder*.

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#### ***What is an Annual Enrollment period?***

Unless otherwise specified, *Annual Enrollment Period* means a period of time during which eligible *Employees* may apply for *Voluntary* life coverage or request changes to their life benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Eligible *Employees* may enroll for coverage, apply for additional coverage, or request changes to their current *Voluntary* benefit program(s) only during the *Annual Enrollment*, unless they qualify because of a *Change in Family Status*.

*Employees* hired after an *Annual Enrollment* period may enroll within 31 days after their eligibility date. If a new *Employee* does not elect *Voluntary* coverage within that time period, he must wait for the next *Annual Enrollment* to enroll unless he qualifies because of a *Change in Family Status*.

Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment* period will become effective on the *Policy* anniversary date.

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#### ***If You are not Actively at Work, when does coverage become effective?***

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an *Injury*, illness or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work*.

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

1. not *Hospital Confined*; or;
2. disabled due to an *Injury* or *Sickness*.

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#### ***What happens if We are replacing an existing Policy? Is continuity of coverage provided?***

If *You* were insured for coverage under the *Prior Policy* on the day immediately preceding *Our Policy*'s Effective Date, and subject to the payment of premiums when due, *We* agree to provide continuity of coverage for *You* and *Your Eligible Spouse* and *Eligible Dependent Children* if *You* are not *Actively at Work* on *Our Policy* Effective Date. If *Your* coverage is extended under this provision, *You* are not eligible for *Waiver of Premium* benefits under *Our Policy*.

Coverage under this provision will end on the earlier of:

1. The date *You* return to *Active Work*, at which time *You* may be covered as an *Actively at Work Insured* under *Our Policy*;
2. The last day of the 12th month following *Our Policy* Effective Date;
3. The last day *You* would have been covered under the *Prior Policy* had the *Prior Policy* not terminated;
4. The date *You* are approved for *Waiver of Premium* under the *Prior Policy*; or
5. The date insurance terminates for one of the reasons stated in the Termination Provisions of *Our Policy*.

The amount of coverage provided will be the lesser of:

1. The amount of coverage *You* had under the *Prior Policy*; or
2. The amount of coverage *You* are eligible for under *Our Policy*.

Reduced by any amount:

1. In-force, paid or payable under the *Prior Policy*; or
2. Which would have been payable if timely election had been made under the *Prior Policy*.

***Prior Policy*** means the group term life insurance policy issued to the *Policyholder* whose coverage terminated immediately prior to *Our Policy* Effective Date.

00009-C

### ***Changes to Your coverage***

A change in *Your* coverage may occur if:

1. *You* Enroll for a different coverage option; or
2. There is a *Policy* change; or
3. *You* enter another class and become eligible for a change in benefits; or
4. *You* experience a qualified *Change in Family Status*

If *You* are eligible for additional coverage due to a *Policy* change, the additional coverage will be effective on the date the *Policy* change is effective, as requested by the *Policyholder* and agreed upon by *Us*.

Additional coverage for reasons other than a *Policy* change will be effective as indicated in the "***When Does Your Contributory insurance become effective?***" section, or the later of:

1. The date *You* enroll for the additional coverage; or
2. The date *You* become eligible for the additional coverage, if enrollment is not required; or
3. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

In order for *Your* additional coverage to begin, *You* must be *Actively at Work*.

Additional *Contributory* coverage is subject to payment of premium.

Any decrease in coverage will take effect immediately.

Exception: Increases or decreases to *Your Voluntary* benefit program elected during the *Annual Enrollment Period* will become effective on the next *Policy* anniversary date, provided *You* are *Actively at Work* on that day.

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### ***Eligibility after You Terminate Employment***

If *Your* coverage ends due to termination of employment, *You* must meet all the requirements of a new *Employee* if *You* are rehired at a later date.

If *You* converted all or part of *Your* group life insurance when employment terminated, the individual policy must be surrendered upon return to *Active Work*.

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## **TERM LIFE INSURANCE BENEFIT**

***THIS BENEFIT ONLY APPLIES TO YOU IF YOU HAVE ELECTED TERM LIFE INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.***

### ***When is a Life Insurance Benefit payable?***

We will pay *Your* beneficiary the amount of life insurance in force as of the date of *Your* death provided:

1. *You* are insured under the *Policy* on the date of death, and
2. We receive *Proof* of death within two (2) years after the date of death.

We will determine the amount of insurance payable based upon the *Schedule of Benefits*.

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### ***Are Life Insurance Benefits payable for death by suicide?***

Life Insurance benefits including Waiver of Premium, increased benefit amounts elected during subsequent *Annual Enrollment periods* and Accelerated Death Benefits, will not be payable for a loss caused by suicide or attempted suicide, while sane or insane, within one (1) year from the effective date of *Your* Term Life Insurance or the effective date of any increased amount of life insurance. *Our* liability for a death claim by suicide will be limited to the return of premium paid for this life insurance.

If *You*:

1. were covered for *Voluntary* life insurance under a prior carrier's policy; and
2. were insured under the *Policy* on its effective date;
3. and there was no lapse in coverage,

We will consider the time *You* were covered under the *Policy* and under the prior carrier's policy in determining if benefits are payable for death by suicide. The death benefit, if payable under this provision, will be the lesser of the benefit under the *Policy* or the benefit under the prior carrier's policy.

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### ***Who will receive Your Life Insurance Benefits?***

*Your* beneficiary designation must be made on a form which *We* provide or on a form accepted by *Us*. If two or more beneficiaries are named, payment of proceeds will be apportioned equally unless *You* had specified otherwise. The *Policyholder* may not be named as beneficiary. Unless *You* provide otherwise, if a beneficiary dies before *You*, *We* will divide that beneficiary's share equally between any remaining named beneficiaries.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, *We* will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. 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.

### ***Facility of Payment***

If no named beneficiary survives *You* or if *You* do not name a beneficiary, *We* will pay the amount of insurance:

1. to *Your* spouse, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than \$1,000 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death. Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.

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***May You change Your beneficiary?***

*You* may change *Your* beneficiary at any time by completing a form provided or accepted by *Us*, and sending it to the *Policyholder*. *Your* written request for change of beneficiary will not be effective until it is recorded by the *Policyholder*. After it has been so recorded, it will take effect on the later of the date *You* signed the change request form or the date *You* specifically requested. If *You* die before the change has been recorded, *We* will not alter any payment that *We* have already made. Any prior payment shall fully discharge *Us* from further liability in that amount.

If *You* are approved for continued life coverage under the Waiver of Premium, *You* may be asked to name a beneficiary. A beneficiary designation made in connection with Waiver of Premium, if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*. Such change of beneficiary only applies while *You* qualify for continued coverage under the Waiver of Premium provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are employed by the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.

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## ***CONVERSION OF LIFE INSURANCE***

***How much Life Insurance may You convert if eligibility terminates?***

*You* may convert to an individual policy of life insurance if *Your* life insurance, or a portion of it, ceases because:

1. *You* are no longer employed by the *Policyholder*; or
2. *You* are no longer in a class which is eligible for life insurance.

In either of these situations, *You* may convert all or any portion of *Your* life insurance which was in force on the date *Your* life insurance ceased.

***How much Life Insurance may You convert if the policy terminates or is amended?***

*You* may also convert to an individual policy of life insurance if *Your* life insurance ceases because:

1. life insurance benefits under the *Policy* cease; or
2. the *Policy* is amended making *You* ineligible for life insurance; however, in either of these situations,

*You* must have been insured under the *Policy*, or the *Policy* it replaced, for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which *You* become eligible under this or any other group policy within 31 days after the date *Your* life insurance ceased; or
2. \$10,000.

***How to apply for conversion***

*We* must receive written application and the first premium for the individual life insurance policy within 31 days after life insurance under the *Policy* ceased. No *Evidence of Insurability* will be required.

The individual policy will be a policy of whole life insurance. It will not contain waiver of premium, accelerated death benefit, disability benefits, accidental death and dismemberment benefits or any other ancillary benefits.

The minimum issue amount of an individual conversion policy is \$2,000. The premium for the individual policy will be based on:

1. *Our* current rates based upon *Your* attained age; and
2. the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which *You* could apply for conversion.

If *You* die during a period when *You* would have been entitled to have an individual policy issued to *You* and if *You* die before such an individual policy became effective, *We* will pay *Your* beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. *Your* death occurred during the 31-day period within which *You* could have made application; and

2. We receive proof of death within two (2) years of the date of death.

If life insurance benefits are paid under the *Policy*, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

Notice. If the *Policyholder* fails to notify *You* at least 15 days prior to the date insurance under the *Policy* would cease, *You* shall have an additional period within which to elect conversion coverage; but nothing herein shall be construed to continue any insurance beyond the period provided for in the *Policy*. The additional election period shall expire 15 days immediately after the *Policyholder* gives *You* notice, but in no event shall it extend beyond 60 days immediately after the expiration of the 31-day period explained above.

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## **WAIVER OF PREMIUM**

### ***What is the Waiver of Premium benefit?***

We will continue *Your* Voluntary life insurance benefit under the *Policy* without further payment of life insurance premium if *You* become *Totally Disabled*, provided:

1. *You* are insured under the *Policy* and were *Actively at Work* on or after the effective date of the *Policy*; and
2. *You* are under the age of 60; and
3. *You* provide *Us* with satisfactory written proof of *Total Disability* within 12 months after the date *You* became *Totally Disabled*; and
4. *Your Total Disability* has continued without interruption for at least 9 months; and
5. *You* are still *Totally Disabled* when *You* submit the proof of disability; and
6. all required premium has been paid.

***Total Disability*** or ***Totally Disabled*** means *You* are diagnosed by a *Doctor* to be completely unable because of *Sickness* or *Injury* to engage in any occupation for wage or profit or any occupation for which *You* become qualified by education, training or experience.

We will waive premium beginning the month after We receive satisfactory proof that *You* have been *Totally Disabled* for at least 9 months. Premium will continue to be waived provided *You*:

1. remain *Totally Disabled*; and
2. provide satisfactory written proof of continuing *Total Disability* upon request.

*You* are responsible for obtaining initial and continuing proof of *Total Disability*.

*You* will be covered for the amount of life insurance in force as of the date *Total Disability* commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as shown on the *Schedule of Benefits* or which are the result of an amendment to the *Policy*, but in no event will the insurance amount increase while *Your* life insurance is continued under Waiver of Premium. This life insurance coverage will continue without the payment of premium until *You* are no longer *Totally Disabled*, or attain the Maximum Waiver of Premium Duration as set forth in the *Schedule of Benefits* or retire, whichever occurs first.

We may have *You* examined at reasonable intervals during the period of claimed *Total Disability*. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if *You* refuse to be examined as and when required.

If *You* are approved for continued coverage under the Waiver of Premium provision, *You* will be asked to name a beneficiary. That beneficiary designation:

1. will only apply while *Your* coverage continues under this Waiver of Premium provision; and
2. if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*.

We will pay the amount of life insurance in force to *Your* beneficiary if *You* die before furnishing satisfactory proof of *Total Disability*, if:

1. *You* die within one year from the date *You* became *Totally Disabled*; and
2. We receive proof that *You* were continuously *Totally Disabled* until the date of death; and
3. We receive proof of death not more than two (2) years after *Your* death.

If continuation of life insurance under the Waiver of Premium provision ceases while the *Policy* is still in force, and *You* are employed by the *Policyholder*, *Your* life insurance will continue provided premium payments begin on the next premium due date. If *You* return to work with the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are no longer employed by the *Policyholder*, *You* may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of this Certificate.

***How does termination of the Policy affect Your insurance under the Waiver of Premium Benefit?***

Termination of the *Policy* will not affect any insurance that has been continued under this Provision prior to the termination date.

***What if You are Totally Disabled and the Policy ends before You satisfy the Elimination Period?***

*Your* coverage under the *Policy* will end if the *Policy* ends before *You* satisfy the *Elimination Period*. However, when the *Policy* ends *You* may be entitled to convert *Your* coverage to an individual plan of life insurance as described in the Conversion of Life Insurance provision.

*You* may still submit a claim for Waiver of Premium Benefits after the *Policy* ends. However, *You* must be *Totally Disabled*, pay the Conversion premium for the full length of the Elimination Period and qualify for the Waiver of Premium Benefits.

***At no time can You be covered under both the individual conversion policy and this Policy.***

Upon receipt of timely notice and due proof of *Your Total Disability* *We* will evaluate *Your* claim. If *We* determine that *You* qualify and *You* pay all applicable premiums, *We* will approve *Your* Waiver of Premium claim under the *Policy* and agree to rescind any individual policy of life insurance issued to *You* under the Conversion privilege. *We* will refund any premiums paid for such coverage. Insurance under the *Policy* will not go into effect until *We* approve your claim in writing.

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## ***ACCELERATED DEATH BENEFIT***

**The benefit paid under this provision may be taxable. If so, *You* or *Your* beneficiary may incur a tax obligation. As with all tax matters, *You* or *Your* beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect *Your* eligibility for Medicaid or other governmental benefits or entitlements.**

### ***What is the Accelerated Death Benefit?***

The *Accelerated Death Benefit* is a percentage of *Your* group *Voluntary* term life insurance which is payable to *You* prior to *Your* death if *We* receive *Proof* that *You* have a *Terminal Condition*. The *Accelerated Death Benefit* is limited to the maximum and minimum amounts shown on the *Schedule of Benefits*, and is payable only once to any one *Insured*.

The *Accelerated Death Benefit* is calculated on the group *Voluntary* term life insurance benefit amount in force under the *Policy* on the date *You* are diagnosed with a *Terminal Condition*.

### ***Who is Eligible for an Accelerated Death Benefit?***

This benefit only applies to *Insureds* with at least the Minimum Covered Life Insurance Benefit amounts set forth in the *Schedule of Benefits*. *You* must have been *Actively at Work* on or after the effective date of the *Policy* to be eligible for an *Accelerated Death Benefit*.

This benefit does not apply to Accidental Death and Dismemberment benefits.

***Terminal Condition*** means *You* have been examined and diagnosed by *Your Doctor* as having a medically determined condition which is expected to result in death within 24 months or any medically determined condition which requires *Your* continuous confinement in an *Eligible Institution*, if *You* are expected to remain there until death. For the purposes of this provision, an *Eligible Institution* means a hospital, an inpatient hospice facility, or an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled nursing services, that is duly licensed by the appropriate governmental authority to provide such services.

### ***The Accelerated Death Benefit Payment***

*We* will pay the benefit during *Your* lifetime if *You* are diagnosed with a *Terminal Condition* if *You* or *Your* legal representative submits a claim for an *Accelerated Death Benefit* and provides satisfactory *Proof*. The benefit will be paid in one sum to *You*.

### ***Are there any exceptions to the payment of the Accelerated Death Benefit?***

The *Accelerated Death Benefit* will not be payable:

1. for any amount of group term life insurance which is less than the Minimum ADB Payment as set forth in the *Schedule of Benefits*; or
2. if *Your Terminal Condition* is the result of:
  - a. attempted suicide, while sane or insane; or
  - b. intentionally self-inflicted injury; or
3. if *Your* group term life insurance benefit has been assigned; or
4. if *Your* group term life insurance benefit is payable to an irrevocable beneficiary, including notification to *Us* that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement.

### ***Notice and Proof of Claim***

*You* must elect the *Accelerated Death Benefit* in writing on a form that is acceptable to *Us*. *You* must furnish *Proof* that *You* have a *Terminal Condition*, including certification by a *Doctor*.

***Proof*** under the Accelerated Death Benefit means evidence satisfactory to *Us* that *You* have a *Terminal Condition*. *We* reserve the right to determine, at *Our* sole discretion, if *Proof* is acceptable.

### ***Effect on Insurance***

The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon *Your* death. When the *Accelerated Death Benefit* is paid:

1. the term life insurance benefit otherwise payable upon *Your* death will be reduced by the amount of the *Accelerated Death Benefit*;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

00020 IL

***What happens to my coverage if I recover from the Terminal Condition?***

If *Your Doctor* certifies that *You* no longer have a *Terminal Condition* and:

1. *You* return to work in an eligible class, coverage will remain in force, provided premium is paid when due.
2. *You* do not return to an eligible class but *You* are approved for continued life insurance coverage under the Waiver of Premium provision, coverage will remain in force, subject to the terms and conditions of the Waiver of Premium provision.
3. *You* do not return to an eligible class, and *You* do not qualify for continued life insurance, coverage will end and *You* may apply for conversion to an individual policy of life insurance in accordance with the applicable terms, conditions and time limits set forth in the Conversion of Life Insurance provision of the *Policy*.

In any event, the amount of coverage eligible to be continued or converted will be reduced by the amount of the *Accelerated Death Benefit* paid.

00021

## ***DEPENDENT LIFE INSURANCE***

***THIS BENEFIT ONLY APPLIES IF YOU HAVE ELECTED DEPENDENT TERM LIFE INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.***

### ***What is the Dependent Life Insurance Benefit?***

We will pay *You* the amount of insurance set forth in the *Schedule of Benefits* on the life of *Your Dependent(s)* while *Your* insurance is in force. Payment will be in one lump sum.

If *You* are not living at the time *Dependent* life insurance benefits become payable, We will pay the benefit:

1. to *Your Spouse*, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and sisters, if living; otherwise
5. to *Your* estate.

### ***Are Life Insurance Benefits payable for death by suicide?***

Life Insurance benefits will not be payable for a loss caused by suicide or attempted suicide, while sane or insane, within one (1) year from the effective date of *Your* covered *Dependent's* Term Life Insurance or the effective date of any increased amount of life insurance. *Our* liability for a death claim by suicide will be limited to the return of premium paid for this life insurance.

If *Your* covered *Dependent(s)*:

1. were covered for *Voluntary* life insurance under a prior carrier's policy;
2. were insured under the *Policy* on its effective date; and
3. and there was no lapse in coverage,

We will consider the time *Your* covered *Dependent(s)* were covered under the *Policy* and under the prior carrier's policy in determining if benefits are payable for death by suicide. The death benefit, if payable under this provision, will be the lesser of the benefit under the *Policy* or the benefit under the prior carrier's policy.

00023

### ***Who is eligible for Dependent Life Insurance?***

If *You* are insured for life insurance under the *Policy* and belong to a class listed in the *Schedule of Benefits* as eligible for *Dependent* Life Insurance benefits, *You* are eligible to enroll for this benefit. If *You* or *Your Spouse* are enrolled for *Dependent* Life Insurance and subsequently acquire a new *Eligible Dependent*, that *Dependent* will automatically be covered.

Note: No eligible person may be covered more than once under the *Policy*. If a person is covered as an *Employee*, he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee*. If both parents are covered as insured *Employees* under the *Policy*, only one may enroll for life insurance coverage on *Eligible Dependent Child(ren)*.

### ***When does Dependent Life Insurance become effective?***

Provided *You*:

1. have completed any required *Employee Eligibility Waiting Period*; and
2. apply for *Dependent* Life Insurance no later than 31 days after becoming eligible for this benefit; and
3. have paid or are obligated to pay any applicable premium.

Life insurance for *Your Eligible Dependent(s)* will become effective on the later of:

1. the date *Your* group insurance coverage becomes effective;
2. the effective date of the *Dependent* Life Insurance benefit;
3. the first of the month that falls on or next follows date *You* enroll *Your Eligible Dependent(s)*;

4. the first of the month that falls on or next follows the date *You* acquire *Your Eligible Dependent(s)*; or
5. if *Evidence of Insurability* is required, the date *We* determine that evidence is satisfactory and *We* provide notice of approval.

If *You* enroll for *Dependent Life Insurance* more than 31 days after *You* are eligible to do so, *You* must furnish *Evidence of Insurability* satisfactory to *Us* for each *Dependent*, and coverage will become effective as set forth above.

If an *Eligible Dependent* is required to submit satisfactory *Evidence of Insurability* for any reason, insurance in the amount for which *We* require such evidence will become effective on the date *We* determine that the evidence is satisfactory and *We* provide notice of approval.

If an *Eligible Dependent* is *Hospital Confined* or *Your* eligible *Spouse* is unable to perform two of the *Activities of Daily Living* on the date coverage would otherwise become effective, insurance will not become effective until the date the *Eligible Dependent* is *No Longer Hospital Confined* or *Your Spouse* is able to perform at least two of the *Activities of Daily Living*.

#### ***When do changes in the Dependent Life Insurance benefit become effective?***

If no *Evidence of Insurability* is required, increases in the amount of *Dependent Life Insurance* will become effective immediately on the date of the change, provided the *Dependent* is not *Hospital Confined* on that day. If the *Dependent* is *Hospital Confined*, the increase will become effective on the date the *Dependent* is *No Longer Hospital Confined*.

For amounts on which *Evidence of Insurability* is required, increases in the amount of *Dependent Life Insurance* will be effective on the date *We* determine that evidence is satisfactory and *We* provide notice of approval by *Us*.

Any decrease in the amount of *Dependent Life Insurance* will become effective immediately on the date of the change.

00024

#### **Definitions which apply to the Dependent Life Insurance provision:**

***Eligible Dependent*** means:

1. *Your* lawful *Spouse* or *Registered Domestic Partner*; and/or
2. *Your* unmarried child(ren) who are within the age limits set forth in the *Schedule of Benefits*, and are not in active military service.

Child includes:

1. *Your* natural or step child or child of *Your Registered Domestic Partner*.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your* dependent for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

Coverage will continue past the age limit for eligible *Dependent Children* who are primarily dependent upon *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. *Proof* of such incapacity must be provided to *Us* upon request.

***No Longer Hospital Confined*** means the *Eligible Dependent* has been discharged from a hospital, nursing home or other medical facility which provides skilled medical care. This provision does not apply to *Your Dependent Child* born while *You* are insured under the *Policy* or covered under the prior policy.

***Spouse*** means lawful spouse. *Spouse* will include *Your Registered Domestic Partner*.

00026b

## ***CONVERSION OF DEPENDENT LIFE INSURANCE***

#### ***Can Dependent Life Insurance be converted if Eligibility Terminates?***

Yes, a *Dependent* may convert to an individual policy of life insurance if his Life Insurance, or any portion of it, ceases because:

1. *You* are no longer employed by the *Policyholder*; or
2. *You* are no longer in a class which is eligible for *Dependent Life Insurance*; or

3. *You* die; or
4. a *Dependent Child* reaches the limiting age under the *Policy*; or
5. a *Dependent Spouse* is no longer eligible as a result of divorce or dissolution of marriage; or
6. a *Dependent* is no longer eligible as defined in this provision.

In any of these situations, the *Dependent* may convert up to the amount which was in force on the date insurance was terminated provided *You* do not elect continued Dependent Life Insurance coverage under the Portability Benefit provision.

***How much can Your covered Dependent convert if the Policy is terminated or amended?***

A *Dependent* may also convert to an individual policy of life insurance if his Life Insurance ceases because:

1. *Dependent* Life Insurance benefits under the *Policy* cease; or
2. the *Policy* is amended making the insured *Dependent* ineligible for *Dependent* Life Insurance; however, he must have been insured under the *Policy*, or the policy it replaced, for at least five (5) years.

The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which the *Dependent* becomes eligible under this or any other group policy within 31 days after the date his Life Insurance ceased; or
2. \$10,000.

***How to apply for conversion***

*We* must receive written application and the first premium for the individual life insurance policy within 31 days after life insurance under the *Policy* ceases. No *Evidence of Insurability* will be required.

The individual policy will be a policy of whole life insurance. It will not contain Accidental Death and Dismemberment benefits or any other supplementary benefits.

The minimum issue amount of an individual conversion policy is \$2,000. The premium for the individual policy will be based on:

1. *Our* current rates based upon the applicant's attained age; and
2. the amount of the individual policy.

If the *Dependent* applies for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which he could apply for conversion.

If the *Dependent* dies during a period when he would have been entitled to have an individual policy issued to him and if he dies before such an individual policy became effective, *We* will pay the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. the death occurred during the 31-day period during which he could have made application; and
2. *We* receive *Proof of death* within two (2) years of the date of death.

If life insurance benefits are paid under the *Policy*, payment will not be made under the converted policy, and *We* will refund any premiums paid for the converted policy.

00027

## **ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)**

**THIS BENEFIT ONLY APPLIES TO YOU IF YOU HAVE ELECTED AD&D INSURANCE  
AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.**

### **COVERAGE PLANS AVAILABLE**

Note: No eligible person may be covered more than once under the *Policy*. If a person is covered as an *Employee*, he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee*. If both parents are covered as insured *Employees* under the *Policy*, only one may enroll for life insurance coverage on *Dependent Child(ren)*.  
00029

#### **What is the AD&D Benefit?**

If, while insured under the *Policy*, *You* or *Your* covered *Dependent* suffer an *Injury* in an *Accident*, *We* will pay for those *Losses* set forth in the "Table of Losses" below. The amount paid will be the percentage stated in the Table of Losses but not more than the Coverage Amount set forth in the *Schedule of Benefits*. The *Loss* must:

1. occur within 365 days of the *Accident*; and
2. be the direct result of the *Accident*.

<b>TABLE OF LOSSES</b>	<b>% OF COVERAGE AMOUNT PAYABLE</b>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger (on same hand)	25%

#### **Definitions which apply to the AD&D Provision:**

**Accident** or **Accidental** means an unexpected event that was not reasonably foreseeable.

**Loss**, with respect to hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, loss means entire and irrecoverable loss of sight. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all *Losses* for any *Insured* resulting from any one *Accident* will not be greater than the Coverage Amount set forth in the *Schedule of Benefits*.

Except as provided in a particular AD&D benefit provision, *We* will pay benefits for loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other *Losses* will be paid to *You*.

00030 IL

## **SEAT BELT BENEFIT**

### **What is the Seat Belt Benefit?**

We will pay an additional amount, as set forth in the *Schedule of Benefits*, if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* were driving or riding in an *Automobile*, if:

1. the *Automobile* is equipped with *Seat Belts*.
2. the *Seat Belt* was in actual use and properly fastened at the time of the *Accident*.
3. the position of the *Seat Belt* is certified in the official report of the *Accident* or by the investigating officer. A copy of the police accident report must be submitted with the claim.
4. *You* were driving or riding in an *Automobile* driven by a licensed driver who was neither:
  - a. intoxicated or driving while impaired. Intoxication and impairment shall be determined, with or without conviction, by the law of the jurisdiction in which the *Accident* occurs or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication; nor
  - b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If the required certification is not available and if it is unclear whether *You* were properly wearing a *Seat Belt*, then We will pay an additional benefit of \$1,000.

**Automobile** means a validly registered private passenger car (or policyholder-owned car), station wagon, jeep-type vehicle, SUV, pick-up truck or van-type car that is not licensed commercially or being used for commercial purposes.

**Seat Belt** means those belts that form an occupant restraint system.

00031

## **AIR BAG BENEFIT**

### **What is the Air Bag Benefit?**

We will pay an additional amount as set forth in the *Schedule of Benefits* if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* are driving or riding in an *Automobile* provided that:

1. *You* were positioned in a seat that was equipped with an *Air Bag*;
2. *You* were properly strapped in the *Seat Belt* when the *Air Bag* inflated; and
3. the police report establishes that the *Air Bag* inflated properly upon impact.

If it is unclear whether *You* were properly wearing *Seat Belt(s)* or if it is unclear whether the *Air Bag* inflated properly, then the Air Bag Benefit will be \$1,000.

**Air Bag** means an inflatable supplemental passive restraint system installed by the manufacturer of the *Automobile*, or proper replacement parts as required by the automobile manufacturer's specifications, that inflates upon collision to protect an individual from injury and death. A *Seat Belt* is not considered an *Air Bag*.

00032

## **REPATRIATION BENEFIT**

### **What is the Repatriation Benefit?**

We will pay an additional amount, as set forth in the *Schedule of Benefits*, for the preparation and transportation of *Your* body to a mortuary if:

1. the Coverage Amount under the AD&D Benefit is payable for *Your* loss of life; and
2. *Your* death occurs at least 75 miles away from *Your* principal residence.

00033

## **EDUCATION BENEFIT**

### **What is the Education Benefit?**

We will pay an additional amount, as set forth in the *Schedule of Benefits to Your Dependent Student* if an AD&D benefit is payable for *Your* loss of life. We will only pay one Education Benefit to any one *Dependent Student* during any one school year. If the *Dependent Student* is a minor, We will pay the benefit to the legal representative of the minor.

**Definitions which apply to the Education Benefit:**

**Student** means an *Eligible Dependent* child who, on the date of *Your* death, is:

1. A full-time post-high school student in a *School of Higher Education*; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a *School of Higher Education* within 365 days after *Your* death.

**School of Higher Education** means an institution which:

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
  - a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
  - b. Gainful employment as long as such program is at least one year of training; and
3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

**When Benefit Ends:** A *Dependent Student* will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. *Our* payment of the fourth installment of the Dependent Education Benefit on behalf of or to the *Dependent Student*; or
2. At the end of the period during which due *Proof* must be submitted if no due *Proof* is submitted.

**Special Child Education Benefit:** If *Your Eligible Dependent* child does not qualify as a *Student*, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of \$1,000. This benefit is payable once upon proof that *You* died as a result of an Accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after *Your* death, *Your Eligible Dependent Child* is a full-time student in an elementary or high school.

00034

**SPOUSE TRAINING BENEFIT**

**What is the Spouse Training Benefit?**

We will pay an additional amount, as set forth in the *Schedule of Benefits*, to *Your Dependent Spouse* if the coverage amount under the AD&D Benefit is payable for *Your* loss of life. The benefit payable is up to the Maximum Spouse Training Benefit set forth in the *Schedule of Benefits*. The benefit is paid annually for the cost of covered expenses incurred within 36 months of *Your* death.

We will pay this benefit if *You*:

1. die within 365 days of and as a result of a covered *Accident*; and
2. are survived by a *Spouse*.

The benefit will be payable for *Your* surviving *Spouse* who:

1. enrolls within 365 days after *Your* death in any *School of Higher Education* for the purpose of training, retraining or refreshing skills needed for employment; and
2. incurs expenses payable directly to or approved and certified by such school.

**School of Higher Education** means an institution which:

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
  - a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
  - b. Gainful employment as long as such program is at least one year of training; and

3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

00035

### **DAY CARE BENEFIT**

#### ***What is the Day Care Benefit?***

We will pay an additional amount, as set forth in the *Schedule of Benefits*, if the *Employee Coverage Amount* under the AD&D Benefit is payable for *Your* loss of life. The benefit is paid annually for the cost of covered expenses incurred, if *You* are survived by a *Dependent Child* who:

1. on the date of the covered *Accident* was enrolled in a legally licensed *Day Care Center*; or
2. is enrolled in a legally licensed *Day Care Center* within 365 continuous days from the date of the covered *Accident*; and
3. is less than 13 years of age.

The Day Care Center Benefit is payable for incurred *Day Care Center* expenses for each child who qualifies:

1. in an amount up to the Day Care Benefit Amount as set forth in the Schedule of Benefits ; and
2. only while the *Dependent* child continues to be enrolled in a legally licensed *Day Care Center*.

We will pay this benefit once a year, at the end of a 12-month period in which there are documented *Day Care Center* expenses, for not more the Maximum Day Care Benefit Duration, as set forth in the *Schedule of Benefits*, or until the child's 13th birthday, whichever happens first.

If at the time of the *Accident*, coverage for a *Dependent Child* is in force, but there is no *Dependent* child who qualifies, we will pay an additional benefit of \$1,500 to *Your* designated beneficiary.

This benefit will be payable to *Your* surviving *Spouse*, if *Your Spouse* has custody of the child. If *You* have no surviving *Spouse*, or *Your* child does not live with *Your Spouse*, then the benefit will be paid to the child's legally appointed guardian.

***Day Care Center*** means a facility which is run according to law, including laws and regulations applicable to child care facilities, and which provides care and supervision for children in a group setting on a regular, daily basis.

A *Day Care Center* does not include: a hospital, the child's home or care provided during normal school hours while a child is attending grades one through twelve.

00036

### **LIMITATIONS**

#### ***Are there any Limitations for losses due to an Accident?***

We will not pay any benefit for any *Loss* resulting from or caused by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except an infection of an *Accidental Injury*; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. while under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. This limitation does not apply if the influence was involuntary or unintentional. Conviction is not necessary for a determination of being under the influence; or
7. direct result of the insured's intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or

8. active participation in a *Riot*. **Riot** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, with a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

*We will not pay any benefit for Loss of life resulting from or caused by war or act of war, if the cause of death occurs while the Insured is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in such forces or within six months after termination of services in such forces.*

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## **UNIFORM PROVISIONS**

*(Applicable to Dismemberment Coverage Only)*

### ***Initial Notice of Claim***

*We* must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

### ***Claim Forms***

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof of Loss* if *We* receive written *Proof*, which describes the occurrence, extent and nature of the *Loss*.

### ***Time Limit for Filing Your Claim***

*We* must receive written *Proof of Loss* within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written *Proof* within 90 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof of Loss* must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid for late claims if it can be shown that:

1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof of Loss* satisfactory to *Us* was given as soon as was reasonably possible.

For the Education Benefit, *Proof of Loss* must:

1. Include *Proof of Dependent Student* status; and
2. Be submitted no later than
  - a. Two months after completion of course work for that particular school year if the *Dependent Student* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall be deemed to begin on September 1st and end on August 31st; or
  - b. Within six (6) months after enrollment in a *School of Higher Education* if the *Dependent Student* is in the 12th grade at the time of *Your* death.

After the first year in a *School of Higher Education*, due *Proof* must be submitted in accordance with the time limits defined in Item (a) above.

### ***Physical Examination/Autopsy***

Upon receipt of a claim, *We* may examine an *Insured*, at *Our* expense, at any reasonable time. *We* reserve the right to perform an autopsy, at *Our* expense, if it is not prohibited by any applicable local law(s).

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4. To a *Spouse*, child or parent due to their serious illness; or
5. For *Your* own serious health condition.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the required premium according to the terms of the *Policy*; and
2. coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the *Policyholder*.

00053a

***When does Dependent Life Insurance coverage end?***

Unless Life and AD&D insurance is continued under the Portability Benefit provision, *Dependent Life Insurance* coverage will end on the earliest of:

1. the date *You* are no longer *Actively at Work* (except in the case of disability, layoff or leave of absence as set forth above); or
2. the date on which the *Policy* is terminated;
3. the date *You* stop making any required contribution toward payment of premiums;
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the date *You*:
  - a. are no longer a member of a class eligible for this insurance,
  - b. request termination of coverage under the *Policy*,
  - c. are retired or pensioned, or
6. the date a *Dependent Child* or *Spouse* no longer meets the *Policy* definition of *Eligible Dependent*.

Note: Coverage will continue past the age limit for eligible *Dependent Children* who are primarily dependent upon *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. *Proof* of such incapacity must be provided to *Us* upon request.

00054

## **GENERAL PROVISIONS**

### ***Entire Contract; Changes***

The *Policy*, the *Policyholder's Application*, the *Employee's* Certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the *Policy* can be amended by mutual consent between the *Policyholder* and *Us*. No change in the *Policy* is valid unless approved in writing by one of *Our* officers. No agent has the right to change the *Policy* or to waive any of its provisions.

### ***Statements on the Application***

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in his signed *Application*; or
2. any *Employee* in applying for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the *Employee*, is or has been given to the *Employee*.

### ***Legal Actions***

Unless otherwise provided by federal law, no legal action of any kind may be filed against *Us*:

1. until 60 days after *Proof* of claim has been given; or
2. more than 3 years after *Proof of Loss* must be filed, unless the law in the state where *You* live allows a longer period of time.

### ***Clerical Error***

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy*; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

### ***Incontestability***

The validity of the *Policy* shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the *Policy* shall not be contested on the basis of a statement made relating to insurability by any person covered under the *Policy* after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

### ***Premium Provisions***

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Voluntary* coverage. The *Policyholder* agrees to remit such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

### ***Misstatement of Age***

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

***Conformity with State Statutes and Regulations***

If any provision of the *Policy* conflicts with the statutes and regulations of the state in which the *Policy* was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

***Assignment***

*You* may assign any incident of ownership *You* may possess of the Life Insurance benefits provided under the *Policy* to anyone other than the *Policyholder*. *We* are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

00055 IL

## ***DEFINITIONS***

**This section tells *You* the meaning of special words and phrases used in this Certificate. To help *You* recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.**

***Actively at Work* or *Active Work*** means that *You* must:

1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the *Schedule of Benefits*: and either:
  - a. work at the *Policyholder's* usual place of business; or
  - b. work at a location to which the *Policyholder's* business requires *You* to travel;
3. be paid regular earnings by the *Policyholder*, and
4. not be a temporary or seasonal *Employee*.

*You* will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Sickness*.

00061

***Activities of Daily Living*** means:

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

00062

***Annual Enrollment Period*** means a period of time prior to the *Policy* anniversary date during which eligible *Employees* may apply for life coverage or request changes to their life benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

00064

***Application*** means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.

00066

***Contributory*** means *You* pay all or a portion of the premium for this insurance coverage.

00070

***Dependent or Eligible Dependent*** means:

1. *Your* lawful *Spouse* or *Registered Domestic Partner*; and/or
2. *Your* unmarried child who is within the age limits set forth in the *Schedule of Benefits*, and who is not in active military service.

**Eligible Dependents** include:

1. *Your* natural or step child or child of *Your Registered Domestic Partner*.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your* dependent for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

00072a

**Doctor** means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Total Disability*, *Terminal Condition* or covered *Loss*, and the treatment provided by the practitioner is within the scope of his or her license.

00073

**Employee** means an *Actively at Work* full-time employee whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, who is *Actively at Work* for the minimum hours per week as set forth in the *Schedule of Benefits* and is reported on the *Policyholder's* records for Social Security and withholding tax purposes.

00074

**Gainful Occupation** means any work or employment in which the insured *Employee*:

1. is or could reasonably become qualified, considering his or her education, training, experience, and mental or physical abilities;
2. could reasonably find work or employment, considering the demand in the national labor force; and
3. could earn (or reasonably expect to earn) a before-tax income at least equal to 60% of his or her pre-disability income.

00078

**Hospital Confined** means that, upon the recommendation of a *Doctor*, *You* are registered as an inpatient in a hospital, nursing home or other medical facility which provides skilled medical care or as an outpatient in a hospital because of surgery. *You* are not *Hospital Confined* if *You* are receiving emergency treatment or if *You* are hospitalized solely because of non-surgical medical or diagnostic test.

00081

**Injury** means bodily injury resulting directly from an *Accident* and independently of disease or bodily infirmity.

00082 IL

**Insured** means an *Employee* or *Eligible Dependent* covered under the *Policy*.

00083

**Male Pronoun** whenever used includes the female.

00088

**Material and Substantial Duties** means duties that are normally required for the performance of *Your Regular Occupation* and cannot be reasonably omitted or modified.

00089

**Policy** means this contract between the *Policyholder* and Us including the attached *Application*, which provides group insurance benefits.

00097

**Policyholder** means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*.

00098

**Proof** under the Accelerated Death Benefit means evidence satisfactory to *Us* that *You* have a *Terminal Condition*. *We* reserve the sole right to determine if *Proof* is acceptable.

00100 IL

**Registered Domestic Partner** means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You*, similar to that of a *Spouse*, as evidenced by the following:

1. *You* and *Your Domestic Partner* share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. *You* and *Your Domestic Partner* each are at least eighteen (18) years of age;
3. *You* and *Your Domestic Partner* are both mentally competent to enter into a binding contract;
4. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and
7. Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

Where the laws of the governing jurisdiction mandate a definition of *Registered Domestic Partner* other than shown above, that definition will be used in the Policy.

00104

**Regular Occupation** means the occupation that *You* are routinely performing when *Your* Life Insurance terminates due to *Disability*. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location.

00105

**Sickness** means illness, disease, pregnancy or complications of pregnancy.

00109

**Voluntary** means coverage for which *You* pay 100% of the premium.

00118

**We, Our** and **Us** means Dearborn Life Insurance Company, Chicago, Illinois.

00119

**You, Your** and **Yours** means the eligible *Employee* to whom this Certificate is issued and whose insurance is in force under the terms of the *Policy*.

00120

## **TRAVEL RESOURCE SERVICES**

### ***What is Travel Resource Services?***

*Travel Resource Services* is a non-insurance benefit made available to **You** which provides access at no additional cost to the following services:

- Access to a toll free number in the event **You** encounter an emergency while traveling more than 100 miles from **Your** principal residence.
- Access to on-line tools and resources for any pre-trip assistance **You** may need.

### ***How is Travel Resource Services accessed?***

**Your** employer will provide **You** with an identification card to be used whenever services are needed. This card will give **You** access to the toll-free number used to initiate the services.

The Travel Resource Services program is administered and provided by Assist America, Inc. Dearborn Life Insurance Company does not underwrite or administer this program.

### ***When do the Travel Resource Services terminate?***

The travel Resource Services terminate if **Your** coverage is terminated under the section on *When does Your coverage under the Policy end?* found in the Termination Provision of the Policy.

00120a IL

**DEARBORN LIFE INSURANCE COMPANY**

**Administrative Office:**

**701 E. 22nd Street**

**Lombard, IL 60148**

**DISCLOSURE NOTICE**

**Accelerated Death Benefit**

**This benefit may be taxable. If so, the *Insured* or his beneficiary may incur a tax obligation. As with all tax matters, the *Insured* or his beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect the *Insured's* eligibility for Medicaid or other governmental benefits or entitlements.**

**DEFINITIONS**

*Accelerated Death Benefit* means 50% of the *Insured's* group term life insurance amount in force on the date that *We* receive satisfactory *Proof* that such *Insured* has a *Terminal Condition*.

*Proof* means evidence satisfactory to *Us* that an *Insured* has a *Terminal Condition*.

*Terminal Condition* means an *Insured* has been examined and diagnosed by his *Doctor* as having a medically determined condition which is expected to result in his death within 24 months, or any medically determined condition which requires his continuous confinement in an *Eligible Institution*, if he is expected to remain there until death. For the purposes of this provision, an *Eligible Institution* means a hospital, an inpatient hospice facility, or an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled nursing services, that is duly licensed by the appropriate governmental authority to provide such services.

**BENEFIT.** *We* will pay an *Accelerated Death Benefit* during the lifetime of an *Insured* if he or his legal representative elects an *Accelerated Death Benefit* and provides satisfactory *Proof* that the *Insured* has a *Terminal Condition*. The benefit will be paid in one sum to the *Insured*. The *Accelerated Death Benefit* amount is limited to a maximum of \$100,000 and a minimum of \$7,500, and is payable only once to any one *Insured*. There is no cost for this benefit.

**EFFECT ON INSURANCE.** The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon the *Insured's* death. When the *Accelerated Death Benefit* is paid:

1. the group term life insurance benefit otherwise payable upon the *Insured's* death, will be reduced by the amount of the *Accelerated Death Benefit*;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

This notice is a brief description of the *Accelerated Death Benefit*. For further details of coverage, including limitations, refer to the *Accelerated Death Benefit* provision in your certificate.

**DEARBORN LIFE INSURANCE COMPANY**

(herein called We, Us, Our)

Administrative Office:

701 E. 22nd Street

Lombard, IL 60148

**AMENDATORY RIDER**

This rider amends the *Policy* or Certificate to which it is attached. It takes effect and ends at the same time as the *Policy* or Certificate. All provisions of the *Policy* or Certificate will apply to this rider, except that in the event of a conflict, the specific provisions of this rider will govern.

The following benefit is added:

**Loss of Use Benefit**

***What is the Loss of Use Benefit?***

If, while insured under the *Policy*, *You* or *Your* covered Dependent suffer a Loss of Use in an *Accident*, which results in a condition listed in the "Table of Losses" below, *We* will pay for those losses as set forth in the "Table of Losses". The Loss of Use Benefit is calculated from the *Employee Spouse* Child Benefit Amount shown on the Schedule of Benefits. The Loss of Use must:

1. occur within 365 days of the *Accident*; and
2. be the direct result of the *Accident*.

**TABLE OF LOSSES**

**% OF COVERAGE  
AMOUNT PAYABLE**

Quadriplegia	100%
Paraplegia	75%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia	50%
Uniplegia	25%

**Definitions which apply to the Loss of Use Benefit:**

***Accident*** or ***Accidental*** means an unexpected event that was not reasonably foreseeable.

***Hemiplegia*** means total *Paralysis* of one arm and one leg on the same side of the body.

***Loss of Speech*** means entire and irrecoverable loss of speech.

***Loss of Hearing*** means entire and irrecoverable loss of hearing in both ears.

***Paralysis*** means loss of use without severance of a limb as a result of an *Injury* to the Spinal Cord, which has continued for 12 months. *Paralysis* must be determined by a *Doctor* to be permanent, total and irreversible.

***Paraplegia*** means total *Paralysis* of both legs.

***Quadriplegia*** means total *Paralysis* of both arms and both legs.

***Uniplegia*** means total *Paralysis* of one limb.

Any claim for the Loss of Use Benefit will be in addition to any other payments afforded under this *Policy*.

**LIMITATIONS**

*We* will not pay any benefit for any *Loss* resulting from or caused by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except an infection which results directly from an *Accidental Injury*; or
3. attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. the *Insured* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless the controlled substance was prescribed for the *Insured* by a licensed physician and the *Insured* used the controlled substance in the manner prescribed. This limitation does not apply if the ingestion of the controlled substance by the *Insured* was involuntary or unintentional. Criminal conviction is not required for *Us* to make a determination that the *Insured* was under the influence; or
7. direct result of the *Insured's* intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Criminal conviction is not required for *Us* to make a determination that the *Insured* was intoxicated; or
8. the *Insured's* active participation in a *Riot*. **Riot** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

#### **UNIFORM PROVISIONS**

*(Applicable to Loss of Use Benefit Only)*

#### **Initial Notice of Claim**

We must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

#### **Telephonic Claim Notification**

In lieu of written proof of claim, We may accept telephonic notice and proof. All time limits in the *Policy* applicable to the filing of proof of loss and commencement of legal actions shall apply to notice and proof filed by telephone or other means acceptable to *Us*.

#### **Claim Forms**

Within 15 days of *Our* being notified in writing of a claim, We will supply the claimant with the necessary claim forms. The claim forms are to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written proof of loss if We receive written proof, which describes the occurrence, extent and nature of the *Loss*.

#### **Time Limit for Filing Proof of Loss for Your Claim**

We must receive written proof of loss within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless the claimant is legally incapacitated, written proof of loss must be given no later than one year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, benefits may be paid for late claims if it can be shown that:

1. it was not reasonably possible to give written proof during the 1 year period, and
2. proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

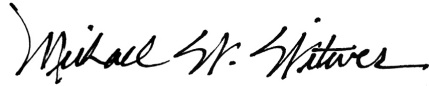
#### **Physical Examination/Autopsy**

Upon receipt of a claim, We may examine an *Insured*, at *Our* expense, at any reasonable time.

All provisions of the Policy or Certificate will apply to this rider, except that in the event of a conflict, the specific provisions of this rider will govern.

Except for the above, this rider does not change the *Policy* in any way.

**DEARBORN LIFE INSURANCE COMPANY**

A handwritten signature in black ink that reads "Michael W. Stover". The signature is written in a cursive style with a large initial "M".

President

## DEARBORN LIFE INSURANCE COMPANY

Chicago, Illinois

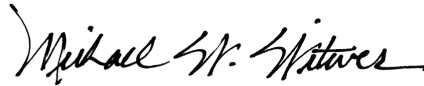
### AMENDATORY ENDORSEMENT

This Amendatory Endorsement amends the Policy or Certificate to which it is attached. It takes effect and ends at the same time as the Policy or Certificate to which it is attached. All provisions of the Policy or Certificate will apply to this Amendatory Endorsement, except that in the event of a conflict, the specific provisions of this Amendatory Endorsement will govern.

The term **Spouse**, wherever it appears in the Policy or Certificate, is amended as follows:

**Spouse** includes a **Party to a Civil Union**.

In addition to civil unions entered into under Illinois law, the term **Civil Union** includes a marriage between persons of the same sex, a civil union, a domestic partnership, or a substantially similar legal relationship, other than common law marriage, legally entered into in another jurisdiction.



President

Nothing contained in this Amendatory Endorsement shall be held to alter or affect any provision or condition of the Policy or Certificate, other than as stated above.

**NOTICE OF  
PROTECTION PROVIDED BY  
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ('the Association') and the protection it provides for policyholders. This safety net was created under Illinois law which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - \$300,000 for death benefits
  - \$100,000 for cash surrender or withdrawal values
- Health Insurance
  - \$500,000 for health benefits plan\*
  - \$300,000 for disability insurance benefits
  - \$300,000 for long-term care insurance benefits
  - \$100,000 for other types of health insurance benefits
- Annuities
  - \$250,000 for withdrawal and cash values

\*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ilhiga.org](http://www.ilhiga.org) or contact:

<i>Illinois Life and Health Insurance Guaranty Association 901 Warrenville Road, Suite 400 Lisle, Illinois 60532-4324</i>	<i>Illinois Department of Insurance 4th Floor 320 West Washington Street Springfield, Illinois 62767</i>
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**Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.**

**The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.**

**END OF CERTIFICATE**

Administrative Office:  
**701 E. 22nd Street**  
**Lombard Illinois 60148**

Principal Office:  
**300 E. Randolph Street**  
**Chicago Illinois 60601**