The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

Group Policyholder: Uplift Education

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on October 1, 2018, and on the same day of each month after that. Policy anniversaries will be each September 1st; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is August 8, 2018.

SECRETARY PRESIDENT

WORKERS' COMPENSATION INSURANCE NOTICE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY. IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS. THE REQUIRED NOTIFICATIONS MUST BE FILED AND POSTED.

GROUP INSURANCE POLICY
No. GL 000403007055
PROVIDING
VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

TOLL-FREE TELEPHONE NUMBERS FOR INFORMATION AND COMPLAINTS

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Lincoln National Life Insurance Company's toll-free telephone number for information or to make a complaint at:
1-800-423-2765.

You may also write to The Lincoln National Life Insurance Company at:
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:
1-800-252-3439.

You may write the Texas Department of Insurance:
P.O. Box #149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presenter una queja:

Usted puede llamar al número de teléfono gratuito de The Lincoln National Life Insurance Company's para obtener información o para presentar una queja al:
1-800-423-2765.

Usted también puede escribir a The Lincoln National Life Insurance Company:
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:
1-800-252-3439.

Usted puede escribir al Departamento de Seguros de Texas a:
P.O. Box #149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Sitio Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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SCHEDULE OF INSURANCE

The amount of an Insured Person's insurance is determined from the following table. The initial amount of coverage is the amount which applies to an Insured Person's Class on the date his or her coverage takes effect. An Insured Person may become eligible for increases in the amount of insurance in accord with the table. Any such increase will take effect on the latest of:

(1) the Policy Anniversary Date which coincides with or follows the date on which the Insured Person becomes eligible for the increase; provided he or she is Actively at Work on that day; or

(2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any decrease will take effect on the Policy Anniversary Date which coincides with or follows the day of the change; whether or not the Insured Person is Actively at Work.

CLASSIFICATION

Class 1	All Full-Time Employees that elect Voluntary Life
Class 2	All Participants with approved Principal Sum of AD&D Insurance Amounts under the Prior Carrier's Plan as of August 31, 2018

WAITING PERIOD: 30 days of continuous Active Work (For date insurance begins, refer to "Effective Date" section)

SCHEDULE OF INSURANCE (CONTINUED)

VOLUNTARY AD&D INSURANCE

	PRINCIPAL SUM FOR INSURED PERSON
Class 1	A Person may elect coverage in $1,000 increments, subject a maximum of $500,000; not to exceed Five Times Basic Annual Earnings (rounded to the next higher $1,000).

DEPENDENT COVERAGE	PRINCIPAL SUM
Spouse	A Person may elect $500 increments, subject to a maximum of 50% of Insured Person's Principal Sum. Coverage is subject to a overall maximum of $100,000.
Each Child	
Dependent Child (age 1 day to 6 months)	$1,000
Dependent Child (age 6 months to 25 years)	$10,000

*Voluntary AD&D Insurance will be reduced as follows:
- At age 65, benefits will reduce by 35% of the original amount; and
- At age 70, benefits will reduce by an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Voluntary AD&D Insurance at age 65 or older, the above age reductions will apply to the maximum amount of insurance for which he or she is eligible.

Voluntary AD&D Insurance for Spouse will be reduced as follows:
- At age 65, benefits will reduce by 35% of the original amount.

Dependents coverage will terminate when the Insured Person retires. Spouse coverage will terminate when the Insured Person attains age 70 or retires, whichever occurs first.

Basic Annual Earnings means the Insured Person's annual base salary or annualized hourly pay from the Group Policyholder before taxes on the Determination Date. The "Determination Date" is the July 1st just prior to the loss.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Group Policyholder. It will not exceed the amount shown in the Group Policyholder's financial records or the amount for which premium has been paid, whichever is less.

Insured Persons are required to make contributions for Voluntary AD&D Insurance.

SCHEDULE OF INSURANCE (CONTINUED)

VOLUNTARY AD&D INSURANCE

	PRINCIPAL SUM FOR INSURED PERSON
Class 2	The Approved Principal Sum of AD&D Insurance under the Prior Carrier's Plan as of August 31, 2018

DEPENDENT COVERAGE	PRINCIPAL SUM
Spouse	The Approved Principal Sum of Spouse AD&D Insurance under the Prior Carrier's Plan as of August 31, 2018
Each Child	
Dependent Child (age 1 day to 6 months)	$1,000
Dependent Child (age 6 months to 25 years)	$10,000

*Voluntary AD&D Insurance will be reduced as follows:
- At age 65, benefits will reduce by 35% of the original amount; and
- At age 70, benefits will reduce by an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Voluntary AD&D Insurance at age 65 or older, the above age reductions will apply to the maximum amount of insurance for which he or she is eligible.

Voluntary AD&D Insurance for Spouse will be reduced as follows:
- At age 65, benefits will reduce by 35% of the original amount.

Dependents coverage will terminate when the Insured Person retires. Spouse coverage will terminate when the Insured Person attains age 70 or retires, whichever occurs first.

Insured Persons are required to make contributions for Voluntary AD&D Insurance.

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an employee's full-time performance of all customary duties of his or her occupation at:

(1) the GROUP POLICYHOLDER'S place of business; or
(2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) an excused or emergency leave of absence (except a medical leave).

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation, whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY OR DATE means at 12:01 A.M., Standard Time, at the GROUP POLICYHOLDER'S place of business; when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place; when used with regard to termination dates.

FULL-TIME EMPLOYEE means an employee of the GROUP POLICYHOLDER:

(1) whose employment with the GROUP POLICYHOLDER is the employee's principal occupation;
(2) who is not a temporary or seasonal employee; and
(3) who is regularly scheduled to work at such occupation at least 30 hours each week.

GROUP POLICYHOLDER means the person, partnership, corporation, or trust as shown on the Title Page of this Policy.

INSURANCE MONTH means that period of time:

(1) beginning at 12:01 A.M. Standard Time, at the GROUP POLICYHOLDER'S place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a PERSON for whom the coverages provided by this Policy are in effect.

PERSON means a FULL-TIME EMPLOYEE of the GROUP POLICYHOLDER:

(1) who is a member of an employee class which is eligible for coverage under this Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by this Policy on Insured Persons.

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

POLICY means this Group Insurance Policy issued by the Company to the Group Policyholder.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:
(1) this Policy and the Group Policyholder's application (a copy is attached); and
(2) the Insured Persons' enrollment cards, if any.

All statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by this Policy; unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement is furnished to the Insured Person or Beneficiary.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in this Policy.

INCONTESTABILITY. Except for the non-payment of premiums, the Company may not contest the validity of this Policy as to any Insured Person after it has been in force for two y0ears during his or her lifetime. This clause will not affect the Company's right to contest claims made for disability, accidental death, or accidental dismemberment benefits.

NONPARTICIPATION. This Policy will not be entitled to share in the surplus earnings of the Company.

BASIS OF RESERVE. The reserve for this Policy will not be less than the reserve computed using:
(1) the 1970 Intercompany Group Life Disability Valuation Table; and
(2) interest at not less than three percent per annum.

INFORMATION TO BE FURNISHED. The Group Policyholder may be required to furnish any information needed to administer this Policy. Clerical error by the Group Policyholder will not:
(1) affect the amount of insurance which would otherwise be in effect; or
(2) continue insurance which otherwise would be terminated.

Once an error is discovered, an equitable adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the twelve month period which precedes the date the Company receives proof such an adjustment should be made.

The Company may inspect any of the Group Policyholder's records which relate to this Policy.

MISSTATEMENT OF AGE. If an Insured Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon the person's correct age.

CERTIFICATES. The Group Policyholder will be furnished with individual Certificates for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

CONFORMITY WITH STATE STATUTES. If any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

WORKER'S COMPENSATION. This Policy is not to be construed to provide benefits required by Worker's Compensation laws.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL INSURANCE

ELIGIBILITY. A Person becomes eligible for the coverage provided by this Policy on the later of:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

WAITING PERIOD. (See Schedule of Insurance)

EFFECTIVE DATE: Personal Insurance becomes effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date the Employee becomes eligible for the coverage;
(2) the date the Person resumes Active Work, if not Actively at Work on the day such Person became eligible; or
(3) the date the Person signs a payroll deduction order and makes written application for Personal Insurance, if any part of the premium for this Policy is paid by Insured Persons.

EXCEPTION. If an Insured Person's coverage terminates due to an approved leave of absence or military leave, the Company will waive any Waiting Period or evidence of insurability requirement upon his or her return; provided:

(1) the reinstated amount does not exceed the amount of insurance which terminated; and
(2) the Person applies or is reenrolled within 31 days after resuming Active Work.

INDIVIDUAL TERMINATIONS

An Insured Person's coverage will terminate on the earliest of:

(1) the date this Policy is terminated;
(2) the last day of the Insurance Month in which such Insured Person requests termination;
(3) the last day of the last Insurance Month for which premium payment is made on behalf of such Insured Person;
(4) the date such Insured Person ceases to be in a class of employees which is eligible for coverage under this Policy;
(5) with respect to any particular insurance benefit, the date that portion of the Policy providing such benefit terminates;
(6) the date on which such Insured Person's employment with the Group Policyholder terminates; or
(7) the date such Insured Person enters the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Person sends proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work results in termination of coverage; except as follows:

(1) If the Insured Person is disabled due to illness or injury, then coverage may be continued during the disability; provided premium payments are made on his or her behalf.
(2) If the cessation of work is due to a temporary lay off, an approved leave of absence, or a military leave; then coverage may be continued three Insurance Months after the lay off or leave began (provided premium payments are made on his or her behalf).

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at the Company's Group Insurance Service Office. The premium must be paid in U.S. dollars.

PREMIUM RATE CHANGE. The Company may change any premium rate on any of the following dates:

(1) the date this Policy's terms are changed;
(2) the date the Company's liability is changed due to a change in federal, state or local law;
(3) the date the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy;
(4) the date any coverage for one or more classes ceases to be provided under this Policy;
(5) the date the number of Insured Persons changes by 25% or more from the enrollment on the date this Policy took effect, or the most recent Rate Guarantee Date expired, if later; or
(6) on any premium due date on or after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 60 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the sum of the products obtained by multiplying each rate shown in the Premium Rate Schedule by the amount of insurance to which the rate applies.

Premium adjustments will not be pro-rated daily. Instead, premium will be adjusted as follows.

(1) When an Insured Person's insurance or increase takes effect, premium will be charged from the monthly due date coinciding with or next following that change.
(2) When all or part of an Insured Person's insurance terminates, the applicable premium will cease on the monthly due date coinciding with or next following that termination.
(3) When premiums are paid other than monthly, increases or decreases will result in adjustment from the premium due date coinciding with or next following that change.

The above manner of charging premium is for accounting purposes only. It will not extend coverage beyond a date it would have otherwise terminated. Each premium payment will include any adjustments in past premiums, which are needed due to changes that have not yet been taken into account. If a premium adjustment involves a return of unearned premium, the refund will be limited to the prior 12-month period.

PREMIUM RATE SCHEDULE

Monthly Voluntary AD&D Rate

Employee Only Coverage	$0.02 per $1,000 of insurance
Spouse Coverage	$0.02 per $1,000 of insurance
Dependent Child(ren)Coverage	$0.02 per $1,000 of insureance

The above rates are guaranteed until September 1, 2021; unless any of the Policy's terms are changed:

(1) as agreed upon by the Group Policyholder and the Company; or
(2) as a result of a change in state or federal law which affects this Policy.

After that, any premium increase will be as shown in the renewal letter.

GRACE PERIOD

A grace period of 60 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period; unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

POLICY TERMINATION

TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 31_days' advance written notice of its intent to do so. The Company may terminate this Policy coverage on the due date of any premium; if:

(1) the total number of Insured Persons is less than 10;
(2) all of the premium is paid by the Group Policyholder and less than 100% of those eligible for coverage are insured;
(3) part of the premium is paid by Insured Persons and less than 25% of those eligible for coverage are insured (this part 3 will not apply to any voluntary, optional or supplemental insurance provided under this Policy);
(4) the Group Policyholder, without good cause, fails to:
    (a) promptly furnish any information the Company reasonably requires; or
    (b) perform its duties pertaining to this Policy in good faith;
(5) the Company terminates all other policies where permitted by their terms, which provide life insurance or weekly disability income insurance in the same state in which this Policy was issued; or
(6) state law otherwise requires this Policy to be terminated.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time, by giving the Company advance written notice. Coverage will then terminate:

(1) on the date the Company receives the notice; or
(2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving sibling or siblings in equal shares; or, if none
(5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has. Such payment will release the Company from any further obligation for the death benefit.

If the person who would otherwise receive payment dies:

(1) within 15 days of the Insured Person's death; and
(2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment card, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT

If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

(1) a person who has assumed the care and support of the Insured Person or Beneficiary;
(2) a person who has incurred expense as a result of the Insured Person's last illness or death;
(3) the personal representative of the Insured Person's estate; or
(4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed $250. Any payment made in good faith under this Section will fully discharge the Company to the extent of the payment.

SETTLEMENT OPTIONS

INSTALLMENTS. All or part of any death or dismemberment benefit may be received in installments by making written election to the Company.

ELECTION. While living, an Insured Person may direct the Company to pay any death or dismemberment benefit in installments. If no such direction is in effect at the time of the Insured Person's death, the person who is to receive payment may make such an election.

CONDITIONS. Any such election must comply with the Company's practices at the time it is made. The amount applied under a settlement option must be at least $2,000. It must be sufficient to provide a payment of at least $20 per month.

DEPENDENTS VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

NOTE: Dependents Voluntary Accidental Death and Dismemberment Insurance is in effect only if the Insured Person has enrolled for the Family Plan and the correct premium has been paid.

DEFINITION. As used in this section, "Dependent" means a person who meets the definition of a dependent of the Insured Person under the U.S. Internal Revenue Code; and who is an Insured Person's:

(1) spouse who is under age 70 and is not legally separated from the Insured Person;
(2) unmarried child at least 1 day but less than 25 years of age;
(3) unmarried child less than 25 years of age, if attending an accredited educational institution for the minimum credit hours required to maintain full-time student status there; or
(4) unmarried child who is totally and permanently disabled and who became so disabled prior to reaching 25 years of age.

A legally adopted child is considered the Insured Person's child from the date of placement in the Insured Person's home for an agency adoption; or from the date the adoption petition is filed, if later, for a private adoption.

In addition to naturally born and legally adopted children, the word "child" includes an Insured Person's stepchild or foster child; provided the child resides in the Insured Person's household, and is dependent on the Insured Person for principal support.

The term "Dependent" does not include a person covered as an Insured Person. A person may be covered as either an Insured Person or a Dependent (but not both at the same time). If a husband and wife are both Insured Persons, their children may be covered as Dependents of either the husband or wife (but not both at the same time).

The term "Dependent" does not include anyone serving on active duty in the armed forces of any state or country; except for duty of 30 days or less for training in the Reserves or National Guard.

ELIGIBILITY. An Insured Person becomes eligible for the Family Plan on the latest of:

(1) the date the Insured Person becomes eligible for Personal Voluntary Accidental Death and Dismemberment Insurance;
(2) the effective date of this section; or
(3) the date the Insured Person first acquires a Dependent.

If an Insured Person acquires a new Dependent while insured under the Family Plan, insurance will become effective as follows.

(1) Insurance for a spouse, stepchild or foster child will take effect on the later of:
    (a) the date the Insured Person is married or takes custody of the child; or
    (b) the 10th day following final discharge from the hospital, if that Dependent is confined in a hospital on the date insurance would otherwise take effect.
(2) Insurance for a newborn natural child will take effect at birth and will continue for 31 days. Insurance will continue beyond 31 days only if any additional required premium is paid by the 31st day following birth.

INDIVIDUAL TERMINATION OF INSURANCE. The Family Plan will cease for all of the Insured Person's Dependents on the earliest of:

(1) the date the Insured Person's Personal Voluntary Accidental Death and Dismemberment Insurance terminates;
(2) the date the Family Plan is discontinued under this Policy;
(3) the date the Insured Person ceases to be in a class eligible for the Family Plan;
(4) the date the Insured Person requests that the Family Plan be terminated; or
(5) the last day of the premium paying period for which the Insured Person has made any required contribution toward the cost of the Family Plan.

Insurance for a particular Dependent will cease on the earliest of:

(1) the date the Dependent ceases to be an eligible Dependent (as defined in this Policy);
(2) the 31st day after the birth of a newborn child or acquisition of an adopted child; unless any additional premium is paid within that 31-day period; or
(3) the day the Dependent enters the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Person sends proof of military service, the Company will refund any unearned premium.)

Termination of one Dependent's insurance due to a status change will not affect the insurance for any other family members who remain eligible Dependents.

CONTINUATION OF INSURANCE FOR A HANDICAPPED CHILD. Voluntary Accidental Death and Dismemberment Insurance may be continued for an unmarried child who is:

(1) incapable of self-sustaining employment because of mental retardation or physical handicap;
(2) chiefly dependent on the Insured Person for support; and
(3) insured under this Policy on the date coverage would otherwise end due to the child's age.

Insurance may be continued so long as the child remains disabled and dependent on the Insured Person for support. Proof of the child's disability must be sent to the Company:

(1) within 60 days of the date coverage would otherwise end due to the child's age; and
(2) as the Company may require after that (but not more than annually after a 2-year period following the child's attainment of the limiting age).

The Insured Person must continue to be covered for Personal Voluntary Accidental Death and Dismemberment Insurance under this Policy. He or she must also continue to pay the required premium. The premium rate for the handicapped child will be that for an Insured Person of like age and sex (not the Dependent rate).

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

DEATH OR DISMEMBERMENT BENEFIT. The Company will pay the benefit listed below, if:

(1) an Insured Person or a Dependent sustains a covered accidental bodily injury while insured under this provision; and

(2) that injury directly causes one of the following losses within 365 days after the date of the accident.

The loss must result directly from the injury and from no other causes.

LOSS	BENEFIT
Loss of Life	Principal Sum
Loss of One Member (Hand, Foot or Eye)	1/2 Principal Sum
Loss of Two or More Members	Principal Sum
Loss of Thumb and Index Finger	1/4 Principal Sum
Loss of Both Speech and Hearing in Both Ears	Principal Sum
Loss of Either Speech or Hearing in Both Ears	1/2 Principal Sum
Loss of Hearing in One Ear	1/4 Principal Sum
Quadriplegia (Paralysis of Both Arms and Both Legs)	Principal Sum
Paraplegia (Paralysis of Both Legs)	1/2 Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	1/2 Principal Sum

The Principal Sum for the Insured Person's class is shown in the Schedule of Insurance. Under a Family Plan, the Principal Sum which applies to each Dependent is also shown. The Principal Sum for a Dependent is based upon family make-up at the time of the loss.

MAXIMUM PER PERSON. If an Insured Person or Dependent sustains more than one loss resulting from the same accident, the benefit:

(1) will be the one largest amount listed; and

(2) will not exceed the Principal Sum for all of that person's losses combined.

TO WHOM PAYABLE. Benefits for the Insured Person's loss of life will be paid in accord with the Beneficiary section. Under a Family Plan, benefits for a Dependent's loss of life will be payable to the Insured Person. Any other benefits will be paid to the Insured Person.

DEFINITIONS. "Beneficiary" means the person(s) named on the Insured Person's enrollment form. The Insured Person may change the Beneficiary by filing a written notice of the change with the Company at its Group Insurance Service Office.

"Loss of a Member" includes the following:

(1) "Loss of Hand or Foot," which means complete severance through or above the wrist or ankle joint. (In South Carolina, "Loss of Hand" can also mean the loss of four whole fingers from one hand.)

(2) "Loss of an Eye," which means total and irrevocable loss of sight in that eye.

"Loss of Thumb and Index Finger" means severance of the thumb and index finger of the same hand, through or above the joint closest to the wrist. (In California, it can also mean loss by complete severance of at least one whole phalanx of each.)

"Loss of Speech" means total and irrevocable loss of audible communication.

"Loss of Hearing" means permanent and total deafness in that ear. The deafness cannot be corrected to any functional degree by any aid or device.

"Paralysis" means complete and irreversible loss or use of an arm or leg (without severance).

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

FELONIOUS ASSAULT BENEFIT. The Company will pay an additional 25% of the Insured Person's Principal Sum, if:

(1) an Insured Person suffers a loss for which an Accidental Death and Dismemberment benefit is payable;
(2) the injury or death takes place while the Insured Person is on the business of, or on any premises of, the Group Policyholder or Employer; and
(3) the injury or death is the direct result of:
    (a) a robbery, holdup, or attempted robbery or holdup;
    (b) a kidnapping during a holdup; or
    (c) a felonious assault.

DEFINITION. "Felonious Assault" means one inflicted by persons other than fellow employees or members of the Insured Person's family or household.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions which follow.

EDUCATION BENEFIT. The Company will pay an Education Benefit to each of the Insured Person's eligible Dependent Children, if the Insured Person:

(1) is injured in a covered accident while insured under the Family Plan;
(2) dies as a direct result of such injuries within 365 days after the accident; and
(3) is survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Education Benefit, a Dependent Child must:

(1) be insured by this provision on the date of the accident; and
(2) be enrolled as a Full-Time Student on the date of the accident or within 365 days after that date.

This benefit will be paid in addition to all other benefits payable under this Policy. The benefit will equal 2% of the Insured Person's Principal Sum, subject to a maximum of $2,000. The benefit will be paid for up to 4 consecutive years. The first payment will be made:

(1) on the date the benefit for accidental loss of life is paid; or
(2) when the Company receives proof that an eligible Dependent Child meets the above requirements, if later.

The second, third and fourth payments will be made when the Company receives proof that the eligible Dependent Child continues to be a Full-Time Student during each additional year.

SPOUSE TRAINING BENEFIT. The Company will pay a Spouse Training Benefit to the Insured Person's surviving Spouse, if the Insured Person:

(1) is injured in a covered accident while insured under the Family Plan;
(2) dies as a direct result of such injuries within 365 days after the accident; and
(3) is survived by a Spouse who is eligible for the benefit.

To be eligible for the Spouse Training Benefit, the Insured Person's Spouse must:

(1) be insured by this provision on the date of the accident; and
(2) be enrolled as a Full-Time Student on the date of the accident or within 365 days after that date.

This benefit will be paid in addition to all other benefits payable under this Policy. The benefit will equal 5% of Insured Person's Principal Sum; subject to a maximum of $5,000. The benefit will be paid for one year. Payment will be made:

(1) on the date the benefit for accidental loss of life is paid; or
(2) when the Company receives proof that the Spouse meets the above requirements, if later.

ALTERNATE BENEFIT. If Family Plan coverage is in force at the time of the accident, but there is no surviving Dependent who is or could become eligible for the Education Benefit or the Spouse Training Benefit; then the Company will pay an additional benefit of $1,000 to the Insured Person's named Beneficiary or estate. Payment will be in addition to all other Policy benefits.

DEFINITION. "Full-Time Student" means the Dependent:

(1) is attending a licensed or accredited college, university or vocational school (beyond the 12th grade);
(2) is considered a full-time student based upon that school's standards; and
(3) incurs expense for tuition, fees, books, room and board, transportation and any other costs paid to or certified by that school.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

COMMON DISASTER BENEFIT. The Company will pay a Common Disaster Benefit if both the Insured Person and covered Spouse:

(1) are injured in a Common Accident while insured under the Family Plan; and
(2) lose their lives as a direct result of such injuries within 365 days after the Common Accident.

The Common Disaster Benefit increases the Spouse's benefit for accidental loss of life to equal the Insured Person's Principal Sum; subject to a maximum of $500,000 for the Spouse's and Insured Person's loss of life combined.

The Spouse's benefit for accidental loss of life will be paid in lieu of any other benefits for his or her loss of member(s), speech, hearing or paralysis as a result of the same accident.

DEFINITION. "Common Accident" means:

(1) the same covered accident; or
(2) separate covered accidents that occur within the same 24-hour period.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

CHILD CARE BENEFIT. The Company will pay a Child Care Benefit to each of the Insured Person's eligible Dependent Children, if the Insured Person:

(1) is injured in a covered accident while insured under the Family Plan;
(2) dies as a direct result of such injuries within 365 days after the accident; and
(3) is survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Child Care Benefit, a Dependent Child must:

(1) be insured by this provision and under age 13 on the date of the accident; and
(2) attend a licensed child care center on a full-time basis on the date of the accident or within 365 days after that date.

The Child Care Benefit is paid in addition to all other Policy benefits. The benefit will equal 2% of the Insured Person's Principal Sum; subject to a maximum of $2,000 for each eligible Dependent Child each year. The benefit will be paid:

(1) for up to 4 consecutive years; or
(2) until the Dependent Child's 13th birthday (whichever occurs first).

The first payment will be made:

(1) on the date the benefit for accidental loss of life is paid; or
(2) when the Company receives proof that an eligible Dependent Child meets the above requirements, if later.

The second, third and fourth payments will be made when the Company receives proof that the eligible Dependent Child continues to attend a licensed child care center on a full-time basis during each additional year.

DEFINITION. "Child Care Center" means any facility (other than a family day care home) which:

(1) is licensed as such by the state; and
(2) provides non-medical care and supervision for children in a group setting; and
(3) cares for children at least 6 but less than 24 hours per day.

EXCLUSIONS. Benefits will not be paid:

(1) when the Dependent Child's care is provided by (or at a facility operated by) the child's grandparent, parent, aunt, uncle or sibling; or
(2) for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

MONTHLY COMA BENEFIT. The Company will pay a Monthly Coma Benefit, while the Insured Person or a covered Dependent remains in a continuous coma; provided:

(1) the coma is caused by an Injury sustained while insured under this Policy;
(2) the coma begins within 365 days after the date of the accident; and
(3) the person remains in the coma for at least 31 days in a row.

The coma must result directly from the Injury and from no other causes.

This Monthly Coma Benefit:

(1) will be payable for each month the person is in a continuous coma; but
(2) in no event will more than 36 months of benefits be paid.

No Monthly Coma Benefit will be paid after the coma ends; whether by death, recovery, or any other change of condition. If, when the coma ends, benefits are due for a period of less than a month; then payment will be prorated. The daily rate will equal 1/30 of the Monthly Coma Benefit.

AMOUNT. The Monthly Coma Benefit will equal 1% of the difference between:

(1) the Principal Sum that would be payable for the Insured Person's or Dependent's accidental death; and
(2) the amount of any benefits paid or payable under this Policy for that person's other Scheduled Losses as a result of the same accident.

In no event will the total benefits payable for all of a person's Scheduled Losses resulting from the same accident exceed the Principal Sum, which would be payable for that person's accidental death.

SUBSEQUENT LOSS. If, the Insured Person or Dependent later suffers another scheduled loss covered by this Policy, due to the same accident that caused the coma; then the benefit paid for the later loss will equal:

(1) the benefit stated in the Schedule of Insurance; reduced by
(2) the total amount of benefits paid, including the Monthly Coma Benefits paid, for the same person's Scheduled Losses as a result of that accident.

If the person continues to qualify for a Monthly Coma Benefit after the other loss; then the amount of the Monthly Coma Benefit will be redetermined, as shown above.

PROOF. The Insured Person or Beneficiary is responsible for providing the Company proof of the continuing coma. The Company retains the right to investigate, to determine whether the coma exists and continues.

TO WHOM PAYABLE. The Monthly Coma Benefit for the Insured Person will be paid in accord with the Beneficiary section. If the Insured Person is insured under the Family Plan, the Monthly Coma Benefit for a covered Dependent will be paid to the Insured Person.

"Coma" means being in a state of complete mental unresponsiveness, with no evidence of appropriate responses to stimulation.

"**Scheduled Loss**" means any of the following losses, if covered under this Policy: loss of life, member(s), speech or hearing, paralysis, permanent total disability, coma or common disaster. It does not include any additional seat belt, felonious assault, child care, education, spouse training, spouse critical period, monthly survivors or monthly in-hospital benefits which may be included under this Policy.

EXCLUSIONS. Benefits will not be paid:

(1) when the person remains in a coma for less than 31 days in a row; or
(2) for any loss excluded under the Voluntary Accidental Death and Dismemberment Exclusions section.

EXCLUSIONS. No benefit will be paid for loss resulting from:

(1) intentionally self-inflicted injury or attempted injury, while sane or insane;
(2) war or any act of war (whether declared or undeclared);
(3) any accident occurring while the Insured Person or covered Dependent is serving on full-time active duty in the armed forces of any state or country (except for duty of 30 days or less for training in the Reserves or National Guard);
(4) travel or flight in (or boarding or leaving) any aircraft or device which can fly above the earth's surface, if:
    (a) the aircraft or device is being used for tests, experimental purposes, or travel beyond the earth's atmosphere (or is designed for such travel);
    (b) the aircraft or device is being used by or for any military authority (except for aircraft flown by the U.S. Military Aircraft Command or similar service of any country);
    (c) the aircraft or device is other than a chartered aircraft; and it is being used by or for the Group Policyholder, Employer or its subsidiary or affiliate (whether it is owned, leased, operated or controlled as defined below);
    (d) the Insured Person or covered Dependent is serving as a pilot, crew member or student taking a flying lesson (and is not riding as a passenger); or
    (e) the Insured Person or covered Dependent is hang-gliding or parachuting (except where he or she must make a parachute jump for self-preservation);
(5) the Insured Person's or covered Dependent's commission of a felony;
(6) sickness, disease or bodily infirmity; except for:
    (a) a bacterial infection resulting from an accidental cut or wound; or
    (b) the accidental ingestion of a poisonous food substance; or
(7) the Insured Person's or covered Dependent's driving a motor vehicle while intoxicated, impaired or under the influence of drugs (except for drugs taken as prescribed by a licensed physician).

DEFINITIONS. As used in this section, "Owned Aircraft" means one the Group Policyholder or Employer holds legal or equitable title to; and can use, alter or sell as desired.

"Leased Aircraft" means one the Group Policyholder or Employer does not own, but can use as desired for the term of a written lease. The time will be longer than a few days or one or two trips. The aircraft cannot be altered or sold without the owner's consent.

"Operated or Controlled Aircraft" means one the Group Policyholder or Employer does not own; but has leased, rented or borrowed and can use as desired for more than 10 straight days. It cannot be altered or sold without the owner's consent.

"Chartered Aircraft" means one the Group Policyholder or Employer does not own; but has hired for one purpose, one trip or general use. The time may not exceed 10 straight days or 15 days in any one year. One or more aircraft hired on a regular or frequent basis are not chartered.

"Intoxicated", "Impaired", or "Under the Influence of Drugs" shall be as defined by the jurisdiction where the accident occurs. The exclusion will apply whether or not the driver is convicted.

DISAPPEARANCE BENEFIT

BENEFIT. The Company will pay a Disappearance Benefit if, while insured for Accidental Death and Dismemberment Insurance under this Policy, the Insured Person's or a covered Dependent's body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which an Insured Person or a covered Dependent was an occupant. It shall be deemed, subject to all other terms and provisions of this Policy, that such Insured Person or a covered Dependent has suffered a loss of life.

The Benefit amount payable will be as defined in the Death or Dismemberment Benefit section of this Policy.

TO WHOM PAYABLE. Benefits for the Insured Person's loss of life will be paid in accord with the Beneficiary section. Under a Family Plan, benefits for a Dependent's loss of life will be payable to the Insured Person.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of this Policy.

EXPOSURE BENEFIT

BENEFIT. The Company will pay an Exposure Benefit, if, while insured for Accidental Death and Dismemberment Insurance under this Policy, the Insured Person or a covered Dependent:

(1) is unavoidably exposed to the elements; and
(2) as a result of such exposure suffers a loss for which benefits are otherwise payable.

The Benefit amount payable will be as defined in the Death or Dismemberment Benefit section of this Policy.

TO WHOM PAYABLE. Benefits for the Insured Person's loss of life will be paid in accord with the Beneficiary section. Under a Family Plan, benefits for a Dependent's loss of life will be payable to the Insured Person. Any other benefits will be paid to the Insured Person.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of this Policy.

REPATRIATION BENEFIT

BENEFIT. The Company will pay a Repatriation Benefit, if:

(1) the Insured Person is insured for Accidental Death and Dismemberment Insurance under this Policy on the date of the Accident;

(2) the Insured Person dies as a result of a covered Accident at least 150 miles from his or her principal place of residence; and

(3) expense is incurred for the preparation and transportation of the Insured Person's body to a mortuary within 50 miles of the Insured Person's place of residence.

This benefit will be in addition to all other benefits payable under this Policy. This benefit will equal the expenses incurred for the preparation and transportation of the Insured Person's body to a mortuary subject to a maximum of $5,000. This benefit will be paid:

(1) when the benefit for Accidental loss of life is paid; or

(2) when the Company receives proof of expense incurred, if later.

PROOF. In order for this benefit to be payable, proof of payment for any expenses incurred for Repatriation must be provided to the Company.

TO WHOM PAYABLE. Benefits for Repatriation will be paid in accord with the Beneficiary section.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of this Policy.

SAFE DRIVER BENEFIT

BENEFIT. If an Insured Person dies as a direct result of a covered auto accident, for which Accidental Death and Dismemberment Benefits are payable; then:

(1) an additional Seat Belt Benefit will be payable, if the Insured Person was wearing a properly fastened seat belt at the time of the accident; and
(2) an additional Air Bag Benefit will be payable, if the auto was equipped with air bag(s).

The Seat Belt Benefit equals $10,000 or 10% of the Principal Sum, whichever is less; and the Air Bag Benefit equals $10,000 or 10% of the Principal Sum, whichever is less. The Seat Belt Benefit and the Air Bag Benefit will not be less than $1,000. The Principal Sum is the amount payable because of the Insured Person's accidental death.

A copy of the police report must be submitted with the claim. The position of the seat belt or presence of an air bag must be certified by:

(1) the official accident report; or
(2) the coroner, traffic officer or other investigating officer.

Upon receipt of satisfactory written proof, the additional benefit will be paid in accord with the Beneficiary section.

DEFINITIONS. As used in this provision:

"Auto" means a 4-wheel passenger car, station wagon, jeep, pick-up truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by the Group Policyholder.

"Intoxicated," "Impaired," or "Under the Influence of Drugs" shall be defined as by the jurisdiction where the accident occurs.

"Seat Belt" means a properly installed:

(1) seat belt or lap and shoulder restraint; or
(2) other restraint approved by the National Highway Traffic Safety Administration.

LIMITATIONS. Safe Driver Benefits will not be paid if:

(1) the Accidental Death and Dismemberment Benefits is not paid under this Policy for the Insured Person's death; or
(2) at the time of the accident, the Insured Person or any other person who was driving the auto in which the Insured Person was traveling:
    (a) was driving without a valid drivers' license;
    (b) was driving in excess of the legal speed limit; or
    (c) was driving while intoxicated, impaired, or under the influence of drugs (except for drugs taken as prescribed by a Physician for the driver's use).

The above limitations will apply, whether or not the driver is convicted.

COMMON CARRIER ACCIDENT BENEFIT

BENEFIT. The Company will increase an Insured Person's or covered Dependent's Death or Dismemberment Benefit to two times the amount otherwise payable, not to exceed $1,000,000; provided the Insured Person or covered Dependent suffers a covered loss from a Common Carrier Accident while insured for Accidental Death and Dismemberment Insurance under this Policy.

MAXIMUM PER PERSON. If an Insured Person or covered Dependent sustains more than one loss resulting from the same accident, then the benefit:

(1) will not exceed two times the Insured Person's or covered Dependent's Principal Sum for all of his or her covered losses combined; and
(2) will not exceed an overall maximum of $1,000,000.

The loss must result directly from the Common Carrier Accident and from no other causes.

TO WHOM PAYABLE. Benefits for the Insured Person's loss of life will be paid in accord with the Beneficiary section. If the Insured Person is insured under the Family Plan, benefits for a covered Dependent's loss will be paid to the Insured Person. Any other benefits will be paid to the Insured Person.

DEFINITIONS.
"Common Carrier Accident" means a covered accidental bodily injury, which is sustained while riding as a fare paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a Common Carrier.

"Common Carrier" means any land, air or water conveyance operated under a license to transport passengers for hire.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of this Policy.

THIRD-DEGREE BURN BENEFIT

BENEFIT. The Company will pay an additional Third-Degree Burn Benefit if, while insured for Accidental Death and Dismemberment Insurance under this Policy, the Insured Person suffers a Third-Degree Burn; which occurs while the Insured Person is performing duties as an Employee of the Group Policyholder or any Participating Employer on premises of the Group Policyholder or Participating Employer.

The Third-Degree Burn Benefit equals $25,000 or 50% of the Principal Sum, whichever is less, payable in a lump sum.

This benefit will be paid in addition to all other benefits paid under this Policy.

PROOF. Upon receipt of satisfactory written proof, the benefit will be paid. Acceptable proof includes:
(1) a copy of the Insured Person's medical report; and
(2) the Group Policyholder or Participating Employer's work accident or incident report.

TO WHOM PAYABLE. Benefits will be paid to the Insured Person.

DEFINITIONS.
"Third-Degree Burn," also called a full-thickness burn, means a burn diagnosed by a Physician as being third-degree, based on the severity of the tissue damage, that destroys the entire depth of skin, over at least 25% of the body surface area as determined by a Physician.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of this Policy.

CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

NOTE: This Policy may include an Extension of Death Benefit, an Accelerated Death Benefit or a Living Benefit. If so, please refer to that section for special claim procedures.

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

(1) the Insured Person's name and address; and
(2) the number of this Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Insured Person or Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

(1) A certified copy of the death certificate, for proof of death.
(2) A copy of any police report, for proof of accidental death or dismemberment.
(3) A signed authorization for the Company to obtain more information.
(4) Any other items the Company may reasonably require in support of the claim.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have the Insured Person examined:

(1) by a Physician of the Company's choice;
(2) as often as reasonably required.

If the Insured Person fails to cooperate with an examiner or fails to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under this Policy will be paid:

(1) immediately after the Company receives complete proof of claim and confirms liability; and
(2) in any event, within 60 days after the Company receives acceptable proof of claim.

TO WHOM PAYABLE

Death. Any benefits payable for the Insured Person's death will be paid in accord with the Beneficiary, Facility of Payment, and Settlement Options sections of this Policy. If this Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

(1) the Insured Person, if he or she survives that Dependent; or
(2) the Insured Person's Beneficiary, or in accord with the Facility of Payment section; if the Insured Person does not survive that Dependent.

Dismemberment. If this Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than the Insured Person's death benefit, will be paid to the Insured Person.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

(1) the reason for the denial, under the terms of this Policy and any internal guidelines;
(2) how the claimant may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within:

(1) 90 days after receiving the first proof of a death or dismemberment claim; or
(2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit available under this Policy.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within:

(1) 180 days after receiving the first proof of a death or dismemberment claim; or
(2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit available under this Policy.

If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:

(1) 60 days after receiving a denial notice of a death or dismemberment claim; or
(2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit available under this Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

(1) any further appeal procedures available under this Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit available under this Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the Insured Person a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from the Insured Person, or from his or her Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code,* Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
  (1) The policyholder has a policy with a company domiciled in Texas;
  (2) The policyholder's state of residence has a similar guaranty association; and
  (3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov