Term Life and AD&D Insurance

Employee Benefit Booklet

Dearborn National

Bexar Appraisal District
VF023727-0001
Class 1-01

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands and Puerto Rico.

01/28/2019
Dearborn National® Life Insurance Company

(A stock life insurance company, herein called “We” “Us” or “Our”)

Having issued Group Policy No. VF023727-0001

(herein called the Policy)

to

Bexar Appraisal District

(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 National Life Insurance Company

Secretary

President

Death Benefits will be reduced if an accelerated death benefit is paid.

DISCLOSURE: The Accelerated Death Benefit offered under this Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Death Benefit qualifies for such favorable tax treatment, the benefits will be excluded from the insured Employee’s income and not subject to federal taxation. Tax laws relating to Accelerated Death Benefits are complex. The insured Employee is advised to consult with a qualified tax advisor about circumstances under which he or she could receive the Accelerated Death Benefit excludable from income under federal law.

Receipt of the Accelerated Death Benefit payment may affect the insured Employee, his or her spouse, or his or her family’s eligibility for public assistance such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. The insured Employee is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect the insured Employee, his or her spouse, or his or her family’s eligibility for public assistance.

Basic Group Term Life Insurance Certificate with Accidental Death & Dismemberment Dependent Life Insurance Benefits

Non-Participating
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SCHEDULE OF BENEFITS

POLICYHOLDER: Bexar Appraisal District
POLICY NUMBER: VF023727-0001
EFFECTIVE DATE: January 1, 2019

ELIGIBILITY: Class 01
All Active Full Time Employees 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 30 hours per week for the Policyholder. Part-time, seasonal and temporary Employees of the Policyholder are not eligible.

Eligibility Waiting Period:
Current Employees: First of the month following 60 Days of continuous, full-time active work
New Employees: First of the month following 60 Days of continuous, full-time active work

Policyholder Contribution:
Basic Life & AD&D 100% of premium
Dependent Life 0% of premium

GROUP TERM LIFE INSURANCE

Employee Basic Life Benefit Amount
2.00 times Annual Earnings from a minimum of $150 to a maximum of $235,000, Plus $15,000, rounded to the next higher $1,000

Annual Earnings means Your gross annual income from the Policyholder. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. Annual Earnings includes income actually received from commissions, but does not include bonuses, overtime pay, or any other extra compensation, or income received from sources other than the Policyholder.

Commissions will be averaged for the lesser of:
   a. the 12 full calendar month period of Your employment with Your Employer just prior to the date of Loss, or
   b. the period of actual employment with Your Employer.

Reduction of Benefits
Basic Group Term Life benefits reduce by 35% of the original amount at age 65 and further reduce to 40% of the original amount at age 70, 25% of the original amount at age 75. 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 6 months
Insured Eligibility Employee
Maximum Waiver of Premium Duration Your Social Security Normal Retirement Age

Accelerated Death Benefit (ADB)
Benefit Amount 75% Basic Term Life Insurance In force
Insured Eligibility Employee
Minimum Covered Life Insurance Amount $15,000
Maximum ADB Payment $250,000
Minimum ADB Payment $7,500

**DEPENDENT TERM LIFE INSURANCE**

*Spouse* Benefit Amount Basic: $5,000

Includes *Registered Domestic Partner*

*Child(ren)* Benefit Amount

- Basic:
  - $1,000 - Age live birth to 15 days
  - $2,000 - age 15 days to 6 months
  - $2,000 - age 6 months to 26 years (or 26 years if full-time student)

**GROUP ACCIDENTAL DEATH & DISMEMBERMENT**

*Employee* Basic AD&D Coverage Amount 2.00 times *Annual Earnings* from a minimum of $150 to a maximum of $235,000, Plus $15,000, rounded to the next higher $1,000

**Reduction of Benefits**

Basic Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 65 and further reduce to 40% of the original amount at age 70, 25% of the original amount at age 75. Benefits terminate at retirement.

**Seat Belt Benefit**

10% of *Employee* Coverage Amount, to a maximum of $10,000

**Air Bag Benefit**

10% of *Employee* Coverage Amount to a maximum of $10,000

**Repatriation Benefit**

Actual costs to a maximum of $5,000

**Education Benefit**

- Benefit Amount 5% of *Employee* Coverage Amount, to a maximum of $5,000 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)

**Day Care Benefit Amount**

- Benefit Amount 5% of *Employee* Coverage Amount to a maximum of $5,000 per year
- Maximum Benefit Duration 4 Years

**Maximum Spouse Training Benefit**

$5,000

**Public Conveyance Benefit**

*Employee* Coverage Amount to a maximum of $250,000

**Coma Benefit Amount**

- Benefit Amount 5% of *Employee* Coverage Amount to a maximum of $5,000 per month
- Maximum Benefit Duration 1 Month
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.

When does Your Noncontributory insurance become effective?
Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Current Employees
If You are an eligible Employee on the Policy effective date, Your Noncontributory coverage under the Policy will become effective on the date indicated in the Schedule of Benefits, provided You are Actively at Work on that day.

New Employees
If You become an eligible Employee after the Policy effective date, Your Noncontributory coverage under the Policy will become effective on the date indicated in the Schedule of Benefits, provided You are Actively at Work on that day.

If You waive all or a portion of Your Noncontributory coverage and choose to enroll at a later date, You are considered a late applicant and must furnish Evidence of Insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the Evidence of Insurability is satisfactory and We provide written notice of approval.

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

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 insurance coverage at any time. 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 coverage within 31 days after Your eligibility date, You are considered a late applicant and must furnish Evidence of Insurability satisfactory to Us before coverage can become effective, unless You qualify because of a Change in Family Status.
   a. Coverage for a late applicant will become effective on the date We determine that the Evidence of Insurability is satisfactory and We provide written notice of approval.
   b. Coverage requested because 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.

Change in Family Status
If You experience a Change in Family Status, You may enroll for coverage, apply for additional coverage, or request changes to Your current 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.

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 apply to increase Your coverage amount during the Policy year; or
5. An increase to Your Annual Earnings results in an increase to Your Life Insurance benefit of more than $50,000, and that amount exceeds the Guarantee Issue Benefit Limit.

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 Your expense.

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.

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.

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.

Changes to Your coverage
A change in Your coverage may occur if:
1. There is a Policy change; or
2. You enter another class and become eligible for a change in benefits; or
3. You experience a qualified Change in Family Status
4. There is a change in Your Annual Earnings, which results in an increased benefit amount

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.

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.
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.

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

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 $250 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.

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.
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.
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.

WAIVER OF PREMIUM

What is the Waiver of Premium benefit?
We will continue *Your* Basic 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. *We* will not request proof of continuing *Total Disability* more frequently than once every three months during the first two years of *Total Disability*, and not more frequently than once a year after the Insured has been *Totally Disabled* for two years.

*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*, but not more frequently than once every three months during the first two years of *Total Disability*, and not more frequently than once a year after the Insured has been *Totally Disabled* for two years. 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.

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

What is the Accelerated Death Benefit?

The Accelerated Death Benefit is a percentage of Your group Basic term life insurance which is payable to You prior to Your death if We receive acceptable 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 Basic term life insurance benefit amount in force under the Policy on the date You are diagnosed with a Terminal Condition. If Your group term life insurance will reduce, due to age, within 12 months after the date We receive proof, the Accelerated Death Benefit will be calculated on the reduced group Basic term life insurance benefit.

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 non-correctable health condition that, with reasonable medical certainty, will result in Your death within 24 months from the date of the Doctor’s Statement.

Doctor’s Statement means a written medical opinion of a Doctor currently licensed to practice in the United States which:
1. is made at Your expense; and
2. indicates that You have a Terminal Condition; and
3. includes all medical test results, laboratory reports, and any other information on which the medical opinion is based; and
4. indicates Your expected remaining life span; and
5. is acceptable to Us.

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. There is no cost for an Accelerated Death Benefit.

At the time of the payment of the Accelerated Death Benefit, We will send a statement to the certificate holder specifying the amount of benefits paid, the effect of the Accelerated Death Benefit payment on the death benefit face amount, and the amount of benefits remaining available for acceleration.

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; or
5. to retirees.
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 a Doctor's Statement within 91 days of the notice of claim. If proof is not given within 91 days, the claim will not be reduced or denied if proof is given as soon as reasonably possible.

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. Any portion of the death benefit remaining after reduction of the death benefit due to payment of an Accelerated Death Benefit shall be paid upon the death of the Insured.
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.

The payment of an Accelerated Death Benefit and the balance of the death benefit under the Policy shall constitute full settlement of the face amount of the Policy.

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.
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.

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.

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

Definitions which apply to the Dependent Life Insurance provision:

Eligible Dependent means:
1. the Spouse or Registered Domestic Partner of each individual eligible to be insured under the Policy;
2. a natural or adopted child of each individual eligible to be insured under the Policy if the child is:
   a. younger than 26 years of age; or
   b. physically or mentally disabled and under the parents' supervision; or
3. a natural or adopted grandchild of each individual eligible to be insured under the Policy if the child is:
   a. younger than 26 years of age; and
   b. a dependent of the insured for federal income tax purposes at the time the application for coverage of the child is made.

Dependent Child - See Dependent or Eligible Dependent

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.

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.

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.

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 TX
ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

What is the AD&D Benefit?

If, while insured under the Policy, You 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 and sole result of the Accident; and
3. be independent of all other causes.

<table>
<thead>
<tr>
<th>TABLE OF LOSSES</th>
<th>% OF COVERAGE AMOUNT PAYABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Entire Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech and Hearing</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Loss of One Hand</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Entire Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Hearing (both ears)</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger (on same hand)</td>
<td>25%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
</tr>
</tbody>
</table>

Definitions which apply to the AD&D Provision:

Accident or Accidental means a sudden, 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,** 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, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

**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.

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.

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### 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.

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### 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.

**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.

**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.

**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.

**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.

**PUBLIC CONVEYANCE BENEFIT**

**What is the Public Conveyance Benefit?**

We will pay an additional amount, as set forth in the Schedule of Benefits, if an AD&D benefit is payable for Your loss of life as the result of an Accident which occurs while You are a fare-paying passenger in a Public Conveyance that;
1. is run by a common carrier regulated by the government; and
2. transports passengers for hire; and
3. is not chartered or other privately arranged conveyance.

Public Conveyance means
1. Any land or water conveyance licensed for the transportation of passengers for hire; or
2. Any aircraft operated by a business organized to operate an aircraft service and licensed for the transportation of passengers for hire.

COMA BENEFIT

What is the Coma Benefit?
We will pay an additional amount, as set forth in the Schedule of Benefits, if You become Comatose as a result of a covered Accident within 31 days of the Accident and remain Comatose beyond the Waiting Period.

We will pay the Coma Benefit as shown on the Schedule of Benefits each month from the end of the Waiting Period. We will cease payment on the earliest of:
1. the end of the month in which You die;
2. the end of the Coma Maximum Benefit Duration; or
3. the end of the month in which You are no longer Comatose.

If You:
1. die from any cause or as a result of the covered Accident while this Coma Benefit is payable; or
2. remain Comatose after this Coma Benefit is payable for the Coma Maximum Benefit Duration, we will pay a lump sum benefit equal to the Coverage Amount payable under the Policy for Accidental death, reduced by the amount of any Accidental dismemberment, loss of sight, speech, hearing, paralysis or Coma benefits paid to You for the Loss caused by the covered Accident.

Coma or Comatose means a state of complete loss of consciousness from which You cannot be aroused and there is no evidence of response to stimulation.

Waiting Period for the purpose of this benefit means the 31 day period from the date You become Comatose.

Exclusion: In addition to the Limitations set forth in this Certificate, the following exclusion applies to this Coma Benefit: Benefits will not be paid for loss covered by or resulting from sickness, disease, bodily infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Bacterial infection that is the natural and foreseeable result of an Accidental Injury or Accidental food poisoning is not excluded.

EXPOSURE AND DISAPPEARANCE

If, as a result of an Accident while insured for this benefit, if You are unavoidably exposed to the elements and suffer a Loss as a result of that exposure, that Loss will be covered. If Your body has not been found within one (1) year of an Accidental disappearance, forced landing, sinking or wrecking of a conveyance in which You were occupants, You will be deemed to have suffered loss of life.

LIMITATIONS

Are there any Limitations for losses due to an Accident?
We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:
1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except a pus-forming infection of an Accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Injury; or
5. war, declared or undeclared, whether or not You are a member of any armed forces; or
6. travel or flight in an 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

7. commission of, participation in, or an attempt to commit an assault or felony; or

8. 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; or

9. 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

10. 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 with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.
**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 91 days after the date a Loss is incurred. If it is not possible to give Us written Proof within 91 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).
TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Your coverage will terminate on the earliest of the following dates. Termination will not affect Your claim for a covered Loss which occurred while the coverage was in force.

1. the date on which the Policy is terminated;
2. the date You stop making any required contribution toward payment of premiums;
3. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
4. 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
   d. are no longer Actively at Work as a result of a disability, layoff, leave of absence, sabbatical, or military leave.

However, You may continue to be eligible for group insurance coverage, as follows:

Disability Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due, the Policy is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

Layoff Until the end of the month following the month during which the layoff began, provided all premiums are paid when due, the Policy is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

Leave of Absence Until the end of the month following the month during which the leave began, or, the period of time in accordance with the FMLA provision below, provided all premiums are paid when due, the Policy is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

Sabbatical Until the end of the month following the sixth month in which the sabbatical began, provided all premiums are paid when due, the Policy is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

Military Leave Until the end of the twelfth month following the month in which the military leave began, provided all premiums are paid when due, the Policy is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

For the purposes of this Termination Provision only, Disability means You are unable to perform all of the Material and Substantial Duties of Your Regular Occupation.

Will coverage be continued if You are eligible for leave under FMLA?

In the event You are eligible for and the Policyholder approves a leave under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, the Policy is in force and Your coverage is not replaced with group life insurance provided by a new carrier, Your insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in Your home; or
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.

When does Dependent Life Insurance coverage end?

Unless life 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.
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.

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, 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.

Retention of Discretion

Dearborn National Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Dearborn National and such decisions shall be final and conclusive.
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
You were not Hospital Confined or disabled due to an Injury or Sickness.

**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).

**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.

**Coma** or **Comatose** means a state of complete loss of consciousness from which You cannot be aroused and there is no evidence of response to stimulation.

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

**Dependent or Eligible Dependent** means:
1. the Spouse or Domestic Partner of each individual eligible to be insured under the Policy;
2. a natural or adopted child of each individual eligible to be insured under the policy if the child is:
   a. younger than 26 years of age; or
   b. physically or mentally disabled and under the parents' supervision; or
3. a natural or adopted grandchild of each individual eligible to be insured under the policy if the child is:
   a. younger than 26 years of age; and
   b. a dependent of the insured for federal income tax purposes at the time the application for coverage of the child is made.

**Dependent Child - See Dependent or Eligible Dependent**

**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.

**Doctor’s Statement** means a written medical opinion of a Doctor currently licensed to practice in the United States which:
   1. is made at Your expense; and
   2. indicates that You have a Terminal Condition; and
   3. includes all medical test results, laboratory reports, and any other information on which the medical opinion is based; and
   4. indicates Your expected remaining life span; and
   5. is acceptable to Us.

**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.

**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.

**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.

**Injury** means bodily injury resulting directly from an Accident and independently of all other causes.

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

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

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

**Non-Contributory** means the Policyholder pays 100% of the premium for this insurance.
**Policy** means this contract between the **Policyholder** and Us including the attached Application, which provides group insurance benefits.

**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.

**Proof** under the Accelerated Death Benefit means evidence satisfactory to Us that You have a Terminal Condition.

**Public Conveyance** means
1. Any land or water conveyance licensed for the transportation of passengers for hire, except one that has been leased by the Policyholder; or
2. Any aircraft operated by a business organized to operate an aircraft service and licensed for the transportation of passengers for hire.

**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.

**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.

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

**Terminal Condition** means You have been examined and diagnosed by Your Doctor as having a non-correctable health condition that, with reasonable medical certainty, will result in Your death within 12 months from the date of the Doctor’s Statement.

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

**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.
IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Dearborn National® Life Insurance Company’s toll-free telephone number for information or to make a complaint at:

**1-800-348-4512**

You may also write to Dearborn National® Life Insurance Company at:
1020 31st Street, Downers Grove, IL 60515-5591

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) 475-1771
Web: http://www.tdi.state.tx.us
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.

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AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Dearborn National® Life Insurance Company’s para obtener información o para presentar una queja al:

**1-800-348-4512**

Usted también puede escribir a Dearborn National® Life Insurance Company at:
1020 31st Street, Downers Grove, IL 60515-5591

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) 475-1771
Sitio Web: http://www.tdi.state.tx.us
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.
DEARBORN NATIONAL® LIFE INSURANCE COMPANY

Chicago, Illinois

RIDER

This Rider is made a part of the Policy or Certificate (hereafter “the Policy”) to which it is attached. It takes effect and ends at the same time as the Policy. All provisions of the Policy, including any other Riders or Amendatory Endorsements will apply to this Rider, except that in the event of a conflict, the specific provisions of this Rider will govern.

Beneficiary Resource Services

What is the Beneficiary Resource Services?
The Beneficiary Resource Services is a non-insurance benefit made available to You or Your beneficiaries which provides access at no additional cost to the following services.

- Unlimited telephone access to grief counselors, legal advisors and financial advisors for up to one year from the date of loss; and,
- Five (5) face-to-face sessions, or equivalent professional time, with a grief counselor, legal advisor and/or a financial advisor for up to one year from the date of loss.

How the Beneficiary Resource Services are accessed

You or Your beneficiaries may access these services by contacting Bensinger, DuPont & Associates at 1-800-769-9187, the program administrator for Beneficiary Resource Services. Additional contact information will be provided at the time a claim for a loss covered under the Policy is made. Dearborn National® Life Insurance Company does not underwrite or administer the Beneficiary Resource Services program.

When do the Beneficiary Resource Services Terminate?
The services available under this Rider will end as follows:

- On the date Your coverage is terminated under the section When Does Your coverage under the Policy end? found in the Termination Provision of the Policy; or
- One year from the date of loss if the loss occurs while the Policy is in effect.

Important Terms

For purposes of this Rider, “date of loss” means the date of death of the named insured or the date the named insured became eligible for benefits under the Accelerated Death Benefit provision of the Policy to which this Rider is attached. If the named insured becomes eligible for and receives benefits under the Accelerated Death Benefits provision of the Policy, and subsequently dies, the date of loss remains the date the named insured became eligible for benefits under the Accelerated Death Benefit provision of the Policy to which this Rider is attached.

President

Nothing contained in this Rider shall be held to alter or affect any provision or condition of the Policy other than as stated above.
NOTICE

to

the Policyholder and Certificateholder Insured under
the Group Term Life Insurance Policy

Provided by Dearborn National Life Insurance Company®

Regarding the Beneficiary Resource Services Noninsurance Benefit

This notice is to advise you that Your Group Term Life Insurance program also provides a non-insurance benefit: Beneficiary Resource Services.

Noninsurance Benefit Description

Beneficiary Resource Services is a service that provides unlimited telephone access to grief counselors, legal advisors and financial advisors, as well as five (5) face-to-face sessions for up to one year following the date of loss. (Date of loss is defined in the Beneficiary Resource Services Rider attached to the Policy.)

This noninsurance benefit is available at the option of the Policyholder without any action required on the part of an insured person to either accept or decline the service.

There is no charge for this service.

The service is currently administered by Bensinger, DuPont & Associates.

Dearborn National Life Insurance Company (sometimes referred to as “We” or “Our”) makes this program available, but it does not underwrite or administer the Beneficiary Resource Services program.

Why This Service is Being Made Available

We are making this service available to provide support and assistance to persons who have suffered a loss that is covered by the group term life insurance policy. The death or terminal illness of a loved one has a significant impact and support services help deal with the grief legal or financial issues experienced during the critical months following a loss.

Accessing Beneficiary Resource Services

Services may be accessed by contacting the program administrator named in the Rider at 1-800-769-9187.

Termination of the Noninsurance Benefit

This noninsurance benefit is provided free of charge. It is subject to termination at our option or at the option of the program administrator.

If We discontinue this service We will notify the Policyholder not less than thirty (30) days in advance of the discontinuance of this service.

If the current program administrator discontinues the program and we are unable to find a replacement, we will notify the Policyholder as soon as is reasonable under the circumstances. If discontinued, the services available under this noninsurance benefit will no longer be available.

Unless terminated by Us or by the Program administrator, the Beneficiary Resource Services noninsurance benefit is available following a covered loss for as long as you remain covered under the group term life insurance policy and such policy remains in effect, subject to the time periods stated above.
DEARBORN NATIONAL® LIFE INSURANCE COMPANY
Chicago, Illinois

RIDER

This Rider is made a part of the Policy or Certificate (hereafter “the Policy”) to which it is attached. It takes effect and ends at the same time as the Policy. All provisions of the Policy, including any other Riders or Amendatory Endorsements will apply to this Rider, except that in the event of a conflict, the specific provisions of this Rider will govern.

Travel Resource Services

What is the 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 Europ Assistance USA, Inc. Dearborn® National 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.

President

Nothing contained in this Rider shall be held to alter or affect any provision or condition of the Policy other than as stated above.
NOTICE
to
the Policyholder and Certificate holder under
the Group Term Life Insurance Policy
Provided by Dearborn National Life Insurance Company

Regarding the Travel Resource Services Noninsurance Benefit

This notice is to advise you that Your Group Term Life Insurance program also provides a non-insurance benefit: Travel Resource Services.

Noninsurance Benefit Description
Travel Resource Services is a service that provides telephonic access to emergency assistance while traveling more than one hundred (100) miles from Your home and access to on-line travel tools and resources when preparing a trip.

This noninsurance benefit is available at the option of the Policyholder without any action required on the part of an insured person to either accept or decline the service.

There is no charge for this noninsurance benefit.

The service is currently administered by Europ Assistance USA, Inc.

Dearborn National Life Insurance Company (sometimes referred to as “We” or “Our”) makes this program available, but it does not underwrite or administer the Travel Resource Services program.

Why This Service is Being Made Available
We are making this service available to provide support and assistance to persons who are traveling or preparing to travel, in addition to the group life and accidental death benefits available under this Policy. If an emergency occurs on a trip, counselors are available to assist in locating nearby hospitals, assist in recovering lost passports, medical evacuations, and other emergencies. Advice at the planning stage of a trip is available.

Accessing Travel Resource Services
Services may be accessed by contacting the program administrator at 1-877-715-2593.

Termination of the Noninsurance Benefit
This noninsurance benefit is provided free of charge as a courtesy. It is subject to termination at our option or at the option of the program administrator.

If We discontinue this service We will notify the Policyholder not less than thirty (30) days in advance of the discontinuance of this service.

If the current program administrator discontinues the program and we are unable to find a replacement, we will notify the Policyholder as soon as is reasonable under the circumstances. If discontinued, the services available under this noninsurance benefit will no longer be available.

Unless terminated by Us or by the Program administrator, the Travel Resource Services noninsurance benefit is available following a covered loss for as long as you remain covered under the group term life insurance policy and such policy remains in effect.
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, and $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 any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one 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

TX Guaranty Association Notice 1114
END OF CERTIFICATE
STATEMENT OF ERISA RIGHTS

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits
   a. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
   b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
   c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries
   In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights
   If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
   Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
   If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claims are frivolous.

4. Assistance with Your Questions
   If you have any questions about your plan, you should contact the plan administrator. If you have questions about this statement or about rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
The benefits described in your certificate are insured by a life insurance policy ("Policy") issued by Dearborn National Life Insurance Company ("Dearborn National" or "Insurer"), pursuant to an "employee welfare benefit plan" ("the Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") established by your employer ("the Company").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a plan administrator. Your plan administrator has delegated the authority to administer claims under the Policy to Dearborn National. As claims administrator, Dearborn National will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The plan administrator is the person or entity responsible for the administration of the Plan. The plan administrator has full discretionary authority and control over the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the plan administrator in the administration of the Plan.

Failure by the Plan or the plan administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the plan administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of Dearborn National and shall be effective as of the date agreed to, in writing by the Plan Sponsor and Dearborn National. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The plan administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to you pursuant to an insurance policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE:

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must follow the claim procedures described in your Group Insurance Certificate by submitting the proper form in writing to Dearborn National at:
For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If Dearborn National uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Life Insurance Plans

Dearborn National will give you a decision no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:
- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed; and
- the steps that have to be followed to have the claim reviewed.

Any denied claim may be appealed to Dearborn National by you or your authorized representative, at the address specified in the claim denial, for a full and fair review. The review will be conducted by a person different from the person who made the initial decision and the reviewer will not review the merits of the claim with the original examiner nor be the original examiner's subordinate. The claimant may:

a) request a review upon written application within 60 days of receipt of claim denial;
b) upon request and free of charge, review pertinent documents, records and other information relevant to the claim and receive copies of same; and
c) submit issues, comments, records, and other information in writing.

A decision will be made by the Insurer no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. Dearborn National will notify you in writing if an extension is needed. If Dearborn National needs information from you and you deliver that information within the time specified, the extension will begin after you provide the information. If you do not provide the information in that time period, Dearborn National may decide your appeal without that information. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision will advise you of any other appeal rights you have under the Plan, as well as your right to bring an action under Section 502(a) of ERISA.
Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands and Puerto Rico.