AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP DISABILITY INSURANCE POLICY

NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the employer's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

Secretary

President

THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY

TABLE OF CONTENTS

POLICY SPECIFICATIONS

POLICYHOLDER:	MEMPHIS FURNITURE GROUP LLC DBA OFFICE INTERIORS
POLICY NUMBER:	51733
POLICY EFFECTIVE DATE:	January 1, 2021
POLICY ANNIVERSARY DATE:	January 1, 2022 and the first day of January each calendar year thereafter.
GOVERNING JURISDICTION:	The state of Tennessee and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES):

All full-time active employees work 30 or more hours a week for the employer.

ELIGIBILITY WAITING PERIOD:

First of the month following 60 days

MONTHLY BENEFIT:

The amount* elected by each insured employee, not to exceed 60% of monthly earnings, subject to a minimum of $400 and a maximum of $2,500.

*Payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this policy. This policy does not cover disabilities due to an occupational sickness or injury.

OPTIONAL RIDERS:

None

GUARANTEED ISSUE LIMIT:

We may ask for evidence of insurability if a person proposed for insurance applies for a monthly benefit amount over $2,500.

ELIMINATION PERIOD:

14 days for disability due to an injury

14 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.

MAXIMUM PERIOD OF PAYMENT:

6 months

POLICY SPECIFICATIONS (Continued)

WAIVER OF PREMIUM:

Premium payments are required while the insured employee is receiving payments under this policy during the first 30 days of disability.

INITIAL RATE:

Monthly rate is determined on the certificate effective date based on the insured employee's issue age on such dates, as follows:

Issue Age	Monthly Rate per $100 of Monthly Benefit
18 to 49	$2.95
50 to 59	$3.94
60 to 64	$5.29
65 to 59	$5.69
70 and over	$6.26

RATE GUARANTEE DATE:

01/01/2023

PREMIUM DUE:

01/01/2021 and the first day of each calendar month thereafter.

All premiums must be sent on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE:

The insured employee pays the cost of coverage.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	Location (City and State)
None	

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date, except for reasons which affect the risk assumed, including the reasons shown below:

1. a change occurs in this policy design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members increases or decreases by 25% or more; or
4. a new law or a change in any existing law is enacted which applies to this policy; or
5. less than 25% of those eligible for coverage are participating.

We will notify the policyholder and each employer participating in the Trust in writing at least 31 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the RATE GUARANTEE provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

WAIVER OF PREMIUM

We do not require premium payment for an insured employee or member after being disabled the longer of 30 days or completion of the elimination period for the duration of that disability. The waiver of the premium will not exceed the maximum benefit period.

We do not require premium payment for an insured employee or member while he or she is receiving disability payments.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder or employer must provide us with the following on a regular basis:

1. information about employees or members:
    a. who are eligible to become insured; and
    b. whose amounts of coverage change; and
    c. whose coverage ends; and
2. occupational information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder or employer records that have a bearing, in our opinion, on this policy must be made available for review by us at any reasonable time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if participation is not met as described in the RATE GUARANTEE provision.

Evidence of insurability is also required if the employee or member:

1. voluntarily canceled coverage and is reapplying; or
2. is applying for an amount of coverage over the Guaranteed Issue Limit; or
3. is applying for the coverage at any time after the initial enrollment period; or
4. is applying for an increase in the amount of coverage, during the re-enrollment period.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder or any employer, made in any applications or employer agreements to participate under the Trust, can be used to void the policy.

POLICYHOLDER PROVISIONS (Continued)

CLERICAL ERROR

Clerical error on the part of the policyholder, by any employer or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder or any employer documenting any clerical errors.

CANCELING POLICY

This policy can be canceled:
1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:
1. less than 25% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 10 people are insured; or
6. the policyholder fails to pay any premium within the 31-day grace period.

If the premium is not paid during the grace period, the policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must send us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both we and the policyholder agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

Coverage with respect to an employer participating in the Trust will terminate according to the terms of the Participation Agreement signed by the employer.

ENTIRE CONTRACT

The contract consists of the following items:
1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member; and
5. the Participation Agreements signed by the employers participating under the Trust.

Any statements made by the policyholder or by an insured employee or member or any employer participating under the Trust, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or insured employee or member or any employer will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the employer or the insured employee or member or his or her personal representative, if any, if such written statement will be used in defense of a claim.

If any of the statements are not complete and/or not true at the time they are made, we can:
1. reduce or deny any claim; or
2. cancel coverage from the original effective date.

POLICYHOLDER PROVISIONS (Continued)

CERTIFICATES OF INSURANCE

We will furnish to the policyholder or each employer participating under the Trust a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members.

(This space intentionally left blank.)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"The policy" means the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE

TABLE OF CONTENTS

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	ELIMINATION PERIOD	MAXIMUM BENEFIT PERIOD	MONTHLY BENEFIT AMOUNT	ANNUAL PREMIUM AMOUNT
GVDICTN	SHORT TERM DISABILITY	14 days for injury 14 days for sickness	6 months	$2,500.00	$XX.XX

TOTAL $XXXX.XX

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
$XXX.XX	$XXX.XX	$XX.XX	$XX.XX	$XX.XX

Premium Payment Method: PAYROLL – MONTHLY

Premium Class: INDUSTRY A

INSURED:	JOHN DOE	ISSUE AGE:	35
EFFECTIVE DATE:	JANUARY 01, 2021	CERTIFICATE NUMBER:	123456
POLICY NUMBER:	51733		
BENEFICIARY:	AS NAMED AT ENROLLMENT OR LATER CHANGED		

GROUP DISABILITY COVERAGE

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective at 12:01 a.m. on the effective date shown on the Certificate Specifications page provided you are an active employee on that date.

If you are not an active employee on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

Any decrease in coverage will take effect on the first day of the calendar month that next follows the date you apply for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
   a. the initial enrollment period; or
   b. a re-enrollment period or at any time, subject to evidence of insurability.
2. You may increase coverage at any time, subject to evidence of insurability.
3. You may decrease coverage at any time.
4. You may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if you:
1. voluntarily canceled coverage and are reapplying; or
2. are applying for an amount of coverage over the Guaranteed Issue Limit; or
3. are applying for coverage, or for an increase in the amount of coverage, during the re-enrollment period; or
4. are applying for the coverage at any time after the initial enrollment period.

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:
1. the date the policy is canceled; or
2. the last day of the period for which any required premium payment was made; or
3. the last day you are an active employee with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder or the employer participating under the Trust, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4 the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

If we accept a premium for coverage extending beyond the date, age or event specified for termination, such premium will be refunded, coverage will terminate and claims will not be paid. We will provide coverage for a payable claim which occurs while you are covered under the policy.

GENERAL PROVISIONS (Continued)

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease active employment with your current employer due to a temporary layoff or leave of absence, and if premiums are paid, coverage will be continued for 3 months following the date active employment ceased.

We will continue your coverage in accordance with your employer's written human resource policy on temporary layoff, leave of absence or family and medical leave of absence, if premium payments continue and the employer approved your leave in writing, for the following periods:

1. If you are on temporary layoff or leave of absence, coverage will be continued for 3 months following the date you ceased active employment.
2. If you are on a Family and Medical Leave of Absence as defined by the Federal Family and Medical Leave Act of 1993, and any amendments, coverage will continue as though you are in active employment. Coverage will continue up to the greater of the leave period required under the:
    a. Federal Family and Medical Leave Act of 1993, and any amendments; or
    b. applicable state law.

If your employer's human resource written policy does not provide for continuation of coverage during a family and medical leave of absence, coverage will be reinstated when you return to active employment.

We will not:

1. apply a new eligibility waiting period; or
2. apply a new pre-existing condition exclusion; or
3. require evidence of insurability.

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 6 years from the time written proof of loss is required to have been furnished.

INCONTESTABILITY

After 2 years from the effective date of your coverage, no misstatement, made in writing, can be used to void coverage or deny a claim for a disability incurred.

CLERICAL ERROR

Clerical error on the part of the policyholder, by any employer or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder or any employer documenting any clerical errors.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

PRE-EXISTING CONDITION LIMITATION

We will not pay for disabilities during the first 12 months of coverage due to a pre-existing condition.

You have a pre-existing condition if:

1. your disability begins in the first 12 months after your effective date of coverage; and
2. you received medical treatment, consultation, care or services, including diagnostic measures, took or were prescribed drugs or medicines, took over the counter medications or followed treatment recommendations in the 12 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective; or
3. you had symptoms in the 12 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior group policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
   a. were in active employment on the policy date of this policy; and
   b. had been continuously insured under this policy since the policy date; and
   c. were insured under the prior group policy when it terminated; and
3. the prior group policy:
   a. had the same policyholder as this policy; and
   b. provided coverage substantially similar to this policy; and
   c. was issued before the policy date of this policy; and
   d. terminated within 60 days of the policy date of this policy.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior individual policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
   a. were in active employment on the policy date of this policy; and
   b. had been continuously insured under this policy since the policy date; and
   c. were insured under the prior individual policy when it terminated; and
3. the prior individual policy:
   a. provided coverage substantially similar to this policy; and
   b. was issued before the policy date of this policy; and
   c. terminated within 60 days of the policy date of this policy.

(This space intentionally left blank.)

EXCLUSIONS

We will not pay benefits for any disabilities that are caused by, contributed to by or result from:

1. Bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression or mental illness. We will pay, however, for covered disabilities resulting from Alzheimer's disease or similar forms of senility or senile dementia first manifested while coverage is in force.
2. War, declared or undeclared, participation in a riot, insurrection or rebellion.
3. Illegal activities or participation in an illegal occupation.
4. Intentionally self-inflicted injury or action.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.
6. Participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.
7. Voluntary inhalation of fumes or gases.
8. Cosmetic surgery (except complications from such surgery will be covered).
9. Pre-existing conditions during the first 12 months of coverage.
10. Occupational sickness or injury, unless covered by an on-the-job disability rider.

We will not pay a benefit for any period of disability during which you are incarcerated.

As used in this provision, mental illness means a psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

As used in this provision, substance abuse means the consuming of alcohol or taking of other drugs at dosages that place your psychological and physical welfare in danger or which habitual influence of such substance (except as prescribed and directed by a doctor) endangers public health, safety or welfare.

As used in this provision, occupational sickness or injury means a sickness or injury that was caused by, contributed to by or aggravated by any employment for pay or profit.

(This space intentionally left blank.)

BENEFIT INFORMATION

GENERAL

The following are shown on the Certificate Specifications page:
1. the elimination period(s); and
2. the monthly benefit amount.

You must be an active employee on the date your disability occurs for disability benefits to be payable.

We may require an exam by a doctor, other medical practitioner, or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require an interview by our authorized representative.

The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

A. Elimination Period

You must be totally disabled continuously throughout the elimination period.

If your covered disability is the result of an injury or sickness that occurs while covered under the policy, the elimination period is the time period stated on the Certificate Specifications page.

B. Monthly Benefit Amount

We pay the monthly benefit amount (or part of the monthly benefit amount, if less than a full month) for a covered disability at the end of the month for which it is due. You will receive benefits as long as you remain totally disabled, except:
1. we pay only up to the maximum benefit period for any one total disability; and
2. any monthly benefit we pay is subject to the DEDUCTIBLE SOURCES OF INCOME provision.

If a monthly benefit is payable for any period less than a full month, we pay 1/30th of the applicable monthly benefit for each day.

When a benefit is due for a payable claim, we will send you a payment each month up to the maximum benefit period. The maximum benefit period during a continuous period of disability is shown on the Certificate Specifications page.

We will stop sending payments and your claim will end on the earliest of the following:
1. when you are able to return to work in your own occupation on a part-time or full-time basis but choose not to do so; or
2. the end of the maximum benefit period; or
3. the date you are no longer disabled under the terms of the policy; or
4. the date proof of your continuing disability is not submitted; or
5. the date of your death.

C. Amount of Payment

When you are totally disabled and not working we will follow the process described below to determine your amount of payment:
1. Multiply your monthly earnings by 60%.
2. Subtract any deductible sources of income from item 1.
3. Determine the lesser of the amount listed on the Certificate Specifications page and the result of item 2.
4. Compare item 3 with the $100 minimum monthly payment and we will pay the greater of the two.

The amount calculated in item 4 is your monthly payment.

After the elimination period, if you continue to be disabled for less than 1 month, we will send 1/30th of your payment for each day of disability.

We may apply this amount toward an outstanding overpayment.

D. Deductible Sources of Income

Deductible sources of income include the amount that you receive, or are eligible to receive, as disability income payments under any:
1. individual disability income policies which are paid for or provided by your employer; or
2. other group insurance coverage which is provided by your employer.

If any individual disability income policies or other group insurance coverage plus the sum of the gross disability benefit and disability earnings exceed 100% of your monthly earnings, we will subtract the amount in excess of 100% from your benefit.

BENEFIT INFORMATION (Continued)

DISABILITY BENEFITS

A. Total Disability Benefit

We pay the monthly benefit amount after the elimination period if we receive sufficient proof that you are totally disabled.

Benefits will not continue beyond the maximum benefit period for total disability.

You are totally disabled when we determine that due to a sickness or injury you are:
1. unable to perform the material and substantial duties of your own occupation; and
2. under the regular care of a doctor; and
3. unable to engage in any occupation.

As used in this provision, any occupation means any gainful occupation for which you are suited by education, training or experience.

B. Partial Disability Benefit

We pay 50% of the monthly benefit if we receive sufficient proof that you are partially disabled, subject to the following:
1. the total disability benefit must have been payable for at least one full month immediately prior to being partially disabled; and
2. the maximum benefit period for a partial disability is 3 months; and
3. for a given period of disability, you may receive either a partial disability benefit, or a total disability benefit, but not both.

Benefits paid under this benefit count towards your maximum benefit period.

You are partially disabled when we determine that due to a sickness or injury you are:
1. unable to perform the material and substantial duties of your own occupation on a full-time basis, but you are able to work on a part-time basis; and
2. under the regular care of a doctor.

C. Concurrent Disability

During any period in which you are disabled due to more than one cause, benefits will be paid as if you are disabled due to only one cause. In no event will being disabled due to more than one cause extend the time for which benefits will be paid under the maximum benefit period.

D. Recurrent Disability

If you have a recurrent disability, we will treat the disability as part of the prior claim and another elimination period will not have to be completed if you were continuously insured under the policy for the period between the prior claim and the recurrent disability and:
1. your recurrent disability occurs within 6 months of the end of your prior claim; or
2. you fully performed any occupation for your employer on a full-time basis for less than 30 full days and your current disability is unrelated to your prior disability for which we made a payment.

Your recurrent disability will be subject to the same terms as your prior claim.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. Your new claim will be subject to all of the policy provisions.

If you become entitled to payments under any other group disability policy, you will not be eligible for payments under our policy.

As used in this provision, recurrent disability means a disability which is:
1. caused by a worsening in condition; or
2. due to the same cause(s) or related cause(s) as the prior disability for which we made a payment.

As used in the provision, any occupation means any gainful occupation for which you are suited by education, training or experience.

DISABILITY BENEFITS (Continued)

E. Pregnancy Benefit

Pregnancy or childbirth will be covered the same as any covered sickness if you meet the definition of total disability, as outlined in the TOTAL DISABILITY BENEFIT provision, provided that your coverage has been in effect for a period of 9 months or more from your effective date of coverage.

F. Organ Donor Benefit

If your disability is the result of your serving as an organ donor in an organ transplant procedure performed while covered under the policy, we will pay the monthly benefit you would receive if you are totally or partially disabled. Sufficient proof that you are totally or partially disabled must be received by us.

As used in this provision, organ transplant means the surgical transplantation of a:
1. kidney; or
2. lung; or
3. portion of the liver, pancreas, or intestines; or
4. bone marrow.

A procedure to have bone marrow removed and stored for your own future use is not considered organ donation.

G. Waiver of Premium

After you have been totally or partially disabled as the result of a covered sickness or injury for 30 or more consecutive days while covered under the policy, or after the elimination period shown on the Certificate Specifications page, whichever is greater, we will waive the premium for this coverage and any attached rider(s) for as long as you remain disabled. The waiver of the premium will not exceed the maximum benefit period shown on the Certificate Specifications page. You must pay all premiums to keep your coverage and any attached rider(s) in force until you have qualified for waiver of premium as described in this provision.

You must send us written notice as soon as you are no longer disabled. We will assume that you are no longer disabled if you:
1. do not send us satisfactory proof of loss when we request it; or
2. notify us that you are no longer disabled.

You must pay all premiums to keep your coverage and any attached rider(s) in force beginning with the first premium due after you are no longer disabled.

Waiver of premium does not apply to any period that you are totally or partially disabled as a result of sickness or injury which is excluded by name or specific description under the policy.

There is no limit to the number of times that you can receive a waiver of premium.

CLAIM INFORMATION

NOTICE OF A CLAIM

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, written proof of your claim must be sent to us no later than 90 days after the elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity. Notice given to us by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the claim form is not received within 15 days of the request, written proof of your claim may be sent to us without waiting for the form.

We must be notified immediately when you return to work in any capacity.

FILING A CLAIM

You and the policyholder must complete your own sections of the claim form and then give it to the attending doctor. The doctor should complete the attending physician statement on the form and send it directly to us. The form will include an additional section for completion by your employer, if different from the policyholder. In this event, the claim form should be forwarded to your employer before it is given to the doctor for completion.

PROOF OF CLAIM

Proof of claim, provided at your expense, must show:

1. proof that you are under the regular care of a doctor whose specialty or expertise is the most appropriate for treating the disabling condition(s) according to generally accepted medical practice;
2. the date your disability began;
3. the cause of your disability;
4. the extent of your disability, including restrictions and limitations preventing you from performing your own occupation;
5. the prognosis of your disability;
6. the name and address of any hospital or institution where treatment was received, including all attending doctors;
7. objective medical findings which support your disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations accepted as standard in the practice of medicine, for the disabling condition(s); and
8. the appropriate documentation of monthly earnings; and
9. proof of active employment on the date your disability began.

We may request that proof of continuing disability be sent to us indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by us.

In some cases, you will be required to give us authorization to obtain additional medical information, and to provide non-medical information as part of the proof of claim, or proof of continuing disability. We will deny a claim, or stop sending payments, if any appropriate information is not submitted.

As used in this provision, generally accepted medical practice means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

CLAIM INFORMATION (Continued)

PAYMENT OF CLAIMS

After receiving written proof of claim, we will immediately pay all benefits then due under this certificate and we will make payments to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:
1. fraud; or
2. any error we make in processing a claim; or
3. your receipt of deductible sources of income.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. In the case of an error in our processing, a recovery can only be made during the 18 months from the date the payment of claim was made. No such restriction will apply to fraudulent overpayments.

We will not recover more money than the amount we overpaid.

UNPAID PREMIUM

Any unpaid premium that is due from you may be deducted from the payment of your claim.

CLAIM REVIEW

If your claim is denied, we will provide written notice of:
1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of your claim; and
4. the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space is intentionally left blank.)

GLOSSARY

Active Employment means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. For the purposes of this coverage:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not your employer's scheduled work days only if you were an active employee on the preceding scheduled work day.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Deductible Sources of Income means income from deductible sources listed in this certificate which you receive while disabled. This income will be subtracted from the gross monthly disability payment.

Doctor means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize you, your spouse, children, parents or siblings as a doctor for a claim that is sent to us.

Eligibility Waiting Period means the continuous period of time that you must be in active employment in an eligible class before eligible for coverage under the policy.

Elimination Period means a period of continuous total disability which must be satisfied before you are eligible to receive benefits from us.

Employee means a person who is a citizen or resident of the United States or Canada in active employment with his or her employer.

Employer means the individual, company or corporation under which you are in active employment, and includes any division, subsidiary, or affiliated company of such employer or an organization participating in the Trust that we have issued coverage under the policy to and are providing coverage to its eligible employees or members according to the terms of the Participation Agreement.

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.

Full-Time Basis means a job at which you have worked 25 or more hours a week for pay or profit.

Gainful Occupation means an occupation that is or can be expected to provide you with an income of the lesser of the gross monthly disability payment or 60% of your prior income within 12 months of your return to work.

Grace Period means the 31 day period of time following the premium due date during which premium payment may be made.

Gross Monthly Disability Payment means the monthly benefit amount before we subtract deductible sources of income.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Initial Enrollment Period means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if you become eligible for coverage after the policy effective date, the period ending 31 days after the date first eligible to apply for coverage.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are insured under the policy will be treated as a sickness. Disability must begin while you are insured under the policy.

Insured Employee or Member means the employee or member covered under the policy.

Material and Substantial Duties means duties that:

1. are normally required for the performance of your own occupation; and
2. cannot be reasonably omitted or modified, except if required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if working or having the capacity to work 40 hours per week.

Maximum Benefit Period means the longest period of time we will make payments to you for any one period of disability.

Member means a member in good standing in the labor union or association named as the policyholder and who is **:** (a) a citizen or resident of the United States; and (b) is (i) engaged in, or (ii) able to engage in and currently seeking, active employment.

Monthly Benefit Amount means the total benefit amount listed on the Certificate Specifications page for which you are insured under the policy subject to the maximum benefit period.

Monthly Earnings means your gross monthly income from your employer in effect just prior to the date of disability. Gross monthly income is the total income before taxes and any pre-tax deductions made under a qualified deferred compensation plan recognized by the Internal Revenue Service. It will always be considered to be 1/12th of the basic annual wage payable by your employer at the start of the term of continuous disability. Regardless of your timing of payment from your employer, it will be considered to be received over a 12 month period. It does not include income received from commissions, bonuses, overtime pay, or other extra compensation. It does not include income received from sources other than your employer.

If you become disabled while on a covered layoff or leave of absence, we will use your gross monthly income from your employer in effect just prior to the date the absence began.

Monthly Payment means your payment after any deductible sources of income have been subtracted from the gross monthly disability payment.

Own Occupation means the occupation you are performing when a period of disability begins. It refers to the occupation as performed in the national economy, rather than for a specific employer in a specific location.

Part-Time Basis means the ability to work and earn between 20% and 80% of your monthly earnings.

Payable Claim means a claim for which we are liable under the terms of the policy.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity or Trust to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if currently enrolled.

GLOSSARY (Continued)

Regular Care means that you:
1. personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat a disabling condition(s); and
2. are receiving appropriate treatment and care of a disabling condition(s), which conforms with standard medical practice, by a doctor whose specialty or experience is the most appropriate for the disabling condition(s), according to standard medical practice.

Sickness means an illness or disease. Disability must begin while you are insured under the policy.

Temporary Layoff or **Leave of Absence** or **Family and Medical Leave of Absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, **Us**, and **Our** means American Heritage Life Insurance Company.

You and **Your** mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space is intentionally left blank.)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE

Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstatebenefits.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstatebenefits.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstatebenefits.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer

1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

NOTICE CONCERNING COVERAGE UNDER
THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy or reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

With these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
    - $100,000 for limited benefits and supplemental health coverages
    - $300,000 for disability and long term care insurance
    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

NOTE

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

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

Tennessee Life and Health Guaranty Association
P.O. Box 190434
Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida

NOTICE TO TENNESSEE POLICYHOLDERS / CERTIFICATEHOLDERS

If you have any questions concerning your policy / certificate please write or call us at:

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive

JACKSONVILLE, FLORIDA 32224-6688

1-800-521-3535