

# Term Life and AD&D Insurance

*Employee Benefit Booklet*



**TEXAS WASTE EQUIPMENT DBA HEIL OF TEXAS**

**GFY95798-0001**

**Class 1-02**

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

**09/28/2011**

# FORT DEARBORN LIFE Insurance Company®

Administrative Office:  
1020 31<sup>st</sup> Street  
Downers Grove IL 60515-5591

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

**Having issued Group Policy No. GFY95798-0001**

(herein called the Policy)

to

**TEXAS WASTE EQUIPMENT DBA HEIL OF TEXAS**

(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 Fort Dearborn 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.

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**Basic Group Term Life Insurance Certificate**  
with  
**Accidental Death & Dismemberment Benefits**  
**Non-Participating**

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION  
(For insurers declared insolvent or impaired on or after September 1, 2005)**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which 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 cover your policy in full or in part due to 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 at that time (**irrespective of the policyholder's residency at policy issue**)
- 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 \$100,000 under one or more contracts on any one life.

**Group Annuities:**

- Present value of allocated benefits up to a total of \$100,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contract holder 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.

**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.**

Texas Life, Accident, Health and Hospital Service  
Insurance Guaranty Association  
6504 Bridge Point Parkway, Suite 450  
Austin, Texas 78730  
800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

Texas Department of Insurance  
P.O. Box 149104  
Austin, Texas 78714-9104  
800-252-3439 or [www.tdi.state.tx.us](http://www.tdi.state.tx.us)

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may contact your \_\_\_\_\_(title)  
at \_\_\_\_\_(telephone number).

You may call Fort Dearborn 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 Fort Dearborn Life Insurance Company at:

**1020 31<sup>st</sup> 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.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

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

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

**AVISO IMPORTANTE**

Para informacion o para someter una queja:

Peude comunicarse con su \_\_\_\_\_(title)  
al \_\_\_\_\_(telephone number).

Usted puede llamar al numero de telefono gratis de Fort Dearborn Life Insurance Company para informacion o para someter una queja al:

**1-800-348-4512**

Usted tambien escribir a Fort Dearborn Life Insurance Company al:

**1020 31<sup>st</sup> Street, Downers Grove, IL 60515-5591**

Peude comunicarse con el Departamento de Seguros de Texas para conseguir informacion acerca de companias, coberturas, derechos o quejas al:

**1-800-252-3439**

Peude escribir al Departamento de Seguros de Texas:

P. O. Box 149104  
Austin, TX 78714-9104  
FAX #(512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con al Departamento de Seguros de Texas.

**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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## **SCHEDULE OF BENEFITS**

**POLICYHOLDER:** TEXAS WASTE EQUIPMENT DBA HEIL OF TEXAS  
**POLICY NUMBER:** GFY95798-0001  
**EFFECTIVE DATE:** September 1, 2011

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**ELIGIBILITY:** ALL OTHER STAFF of the Policyholder working in the United States of America who are  
**Class 02** 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*: None  
New *Employees*: First of the month following 90 Days of continuous, full-time active work

**Policyholder Contribution:** Basic Life & AD&D 95% of premium

### **GROUP TERM LIFE INSURANCE**

**Employee Basic Life Benefit Amount** \$15,000

**Reduction of Benefits** Basic Group Term Life benefits reduce by 35% of the original amount at age 65 and further reduce to 50% of the original amount at age 70. Benefits terminate at retirement.

#### **Waiver of Premium**

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

Insured Eligibility *Employee*

Maximum Waiver of Premium Duration age 65

#### **Accelerated Death Benefit (ADB)**

Benefit Amount 50% Basic Term Life Insurance In force

Insured Eligibility *Employee*

Minimum Covered Life Insurance Amount \$15,000

Maximum ADB Payment \$150,000

Minimum ADB Payment \$7,500

### **GROUP ACCIDENTAL DEATH & DISMEMBERMENT**

**Employee Basic AD&D Coverage Amount** \$25,000

**Reduction of Benefits** Basic Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 65 and further reduce to 50% of the original amount at age 70. Benefits terminate at retirement.

**Seat Belt Benefit** 10% of *Employee* Coverage Amount, to a maximum of \$25,000

**Air Bag Benefit** 5% of *Employee* Coverage Amount to a maximum of \$5,000

**Repatriation Benefit** Actual costs to a maximum of \$5,000

#### **Education Benefit**

Benefit Amount 3% of *Employee* Coverage Amount, to a maximum of \$3,000 per year

Maximum Benefit Duration Benefit payable for a maximum of four (4) years

Eligible Dependents Age live birth to age 19 years (25 if a full-time student)

## ***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.

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### ***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, 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.

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### ***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.

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

*Evidence of Insurability* is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date; or
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.

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*.

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

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an *Injury*, illness or layoff,

*Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work*.

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

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

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***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*

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.

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

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

Exception: If *Your* coverage ends due to termination of employment and *You* return to *Active Work* in an eligible class within 6 months, we will not:

1. apply a new *Eligibility Waiting Period*

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

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## **TERM LIFE INSURANCE BENEFIT**

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

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

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

1. *You* are insured under the Policy on the date of death, and
2. *We* receive proof of death.

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

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

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

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, *We* will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent *Us* from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

### **Facility of Payment**

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

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

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than \$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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### ***How to apply for conversion***

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

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

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

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

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

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

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

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

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

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### **WAIVER OF PREMIUM**

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

*We* will continue *Your* 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 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 12 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.

00020 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 OF LOSSES	% OF COVERAGE AMOUNT PAYABLE
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Quadriplegia	100%
Paraplegia	75%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia	50%
Loss of Thumb and Index Finger (on same hand)	25%
Uniplegia	25%

### 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*.

00030

### ***SEAT BELT BENEFIT***

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

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

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

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

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

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

00031

### ***AIR BAG BENEFIT***

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

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

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

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

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

00032

### **REPATRIATION BENEFIT**

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

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

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

00033

### **EDUCATION BENEFIT**

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

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

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

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

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

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

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

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

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

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

Death & Dismemberment benefit is payable and that, within 12 months after *Your* death, *Your Eligible Dependent Child* is a full-time student in an elementary or high school.

00034

### ***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.

00043

### ***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.

00050

### ***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).

00051 TX

## **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 of absence 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 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 proved 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*.

00052TXa

***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*.

00053a

## **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***

Fort Dearborn 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 Fort Dearborn 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*.

00061

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

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

00062

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

00066

***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 *Your* changing from part-time to full-time, or full-time to part-time.

00068-A

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

00070

**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. unmarried and younger than 25 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. unmarried;
  - b. younger than 25 years of age; and
  - c. 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*

00072 TX

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

00073

**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.

00125TX

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

00074

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

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

00078

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

00081

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

00082

**Insured** means an Employee covered under the Policy.

00083

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

00088

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

00089

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

00097

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

00098 TX

**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

Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

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

00104

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

00105

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

00109

**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*.

00115 TX

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

00119

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

00120

**FORT DEARBORN 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.

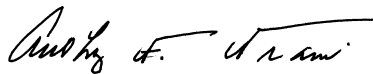
***How is Travel Resource Services accessed?***

**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. Fort Dearborn Life Insurance Company® does not underwrite or administer this program.

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

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



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.
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**NOTICE**  
*to*  
**the Policyholder and Certificate holder under**  
**the Group Term Life Insurance Policy**  
**Provided by Fort Dearborn 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.

Fort Dearborn 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.

<b>ERISA INFORMATION STATEMENT*</b>
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The benefits described in your certificate are insured by a Policy issued by Fort Dearborn Life Insurance Company ("FDL"), pursuant to an Employee Welfare Benefit Plan ("the Plan") established by your employer ("the Company"). This ERISA Information Statement ("EIS") describes some of the key provisions of the Plan in effect as of the Effective Date of the Policy.

It is not the intention of the EIS to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the EIS or in the event of any conflict between the EIS and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from this EIS.

#### **A. ADMINISTRATION OF THE PLAN**

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer 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 amendment, termination or suspension shall be executed according to the Employer's authorized procedures. 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 FDL and shall be effective as of the date agreed to, in writing by the Plan Sponsor and FDL. 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. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. FDL's (the Insurer's) services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- 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 \* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

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.

## **B. CLAIMS PROCEDURE:**

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form in writing. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist FDL in the claims processing for this Plan or by contacting FDL directly at:

Claims Department  
Fort Dearborn Life Insurance Company  
1020 31<sup>st</sup> Street  
Downers Grove, IL. 60515-5591  
1-800-778-2281

**For the purpose of this Section, including Subsections 1 and 2 below, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If FDL uses electronic notices, it will do so in accordance with 29 CFR 2520.104b- 1©(i), (iii) and (iv).**

### **1. Disability Insurance Plans**

FDL will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, FDL notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If the extension is due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you 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;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

- a. request a review upon written application within 180 days of the claim denial;
- b. request, free of charge, copies of all documents, records and other information relevant to your claim; and

\* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

- c. submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

FDL will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, FDL notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

## **2. Life Insurance Plans**

FDL 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 the Insurer for a full and fair review. 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. 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.

## **C. ERISA NOTICE OF YOUR RIGHTS**

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the 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 employers, your union, or any other persons, 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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the

\* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a 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 Plan 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 federal court. The court will decide who should pay 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, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

#### **D. PARTICIPANT'S RIGHTS**

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.

\* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.



Administrative Office:  
1020 31<sup>st</sup> Street • Downers Grove, Illinois 60515-5591

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