New York Life Insurance Company
(A Mutual Company Founded in 1845)
51 Madison Avenue, New York, NY 10010
1-800-225-5695
http://www.newyorklife.com

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AND THE ACCELERATED DEATH BENEFIT CERTIFICATE OF COVERAGE

Life insurance provides financial protection by paying a benefit in the event of death. Accidental death and dismemberment insurance provides financial protection by paying a benefit in the event of accidental death or other covered loss.

THE ACCELERATED DEATH BENEFIT PROVIDES FINANCIAL PROTECTION BY PAYING ALL OR A PORTION OF THE LIFE INSURANCE BENEFIT IN THE EVENT OF TERMINAL ILLNESS. THE LIFE INSURANCE BENEFIT WILL BE REDUCED BY THE AMOUNT OF THE ACCELERATED DEATH BENEFIT, WHEN IT IS PAID. YOU ARE ADVISED TO SEEK ADDITIONAL INFORMATION FROM YOUR PERSONAL TAX ADVISOR ABOUT THE TAX STATUS OF ACCELERATED DEATH BENEFIT PROCEEDS.

POLICYHOLDER: **GERRITY'S SUPERMARKET**

POLICY NUMBER: **54433386**

POLICY EFFECTIVE DATE: **11/01/2018**

GOVERNING JURISDICTION: **PENNSYLVANIA**

New York Life Insurance Company (referred to as New York Life) welcomes **you** as a **certificateholder**. This is **your** Certificate of Coverage as long as **you** are eligible for coverage and **you** become insured. **Your** benefits and rights under the policy will not be less than those stated in this Certificate of Coverage. **We certify that you are insured for the benefits described in this Certificate of Coverage, subject to the provisions of this Certificate of Coverage. READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS.**

Your coverage may be canceled or changed under the terms and provisions of the policy. Contact the **Policyholder** if **you** wish to inspect a copy of the policy. **We** will only make changes that are consistent with Interstate Insurance Product Regulation Commission standards and any endorsements or amendments used to effect such changes are subject to prior approval by the Interstate Insurance Product Regulation Commission.

If the terms and provisions of the Certificate of Coverage (issued to **you**) are different from the policy (issued to the **Policyholder**), the policy will govern. **Your** coverage may be canceled or changed under the terms and provisions of the policy.

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.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
The policy and this certificate have been approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the policy and this certificate that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for group term life insurance is hereby amended to conform to the Interstate Insurance Product Regulation Commission standards for group term life insurance as of the provision's effective date.

Amy Miller
Secretary

President

The insurance department name and phone number of the Governing Jurisdiction appears on the listing following the Table of Contents.

CERTIFICATE OF COVERAGE
TABLE OF CONTENTS

STATE INSURANCE DEPARTMENT CONTACT LISTING

State	Insurance Department	Main Phone
Alabama	Alabama Department of Insurance	(334) 269-3550
Alaska	Alaska Division of Insurance	(907) 269-7900
Arizona	Arizona Department of Insurance	(602) 364-2499
Arkansas	Arkansas Insurance Department	(501) 371-2600
Colorado	Colorado Division of Insurance	(303) 894-7499
Georgia	Georgia Department of Insurance	(404) 656-2056
Hawaii	Hawaii Insurance Division	(808) 586-2790
Idaho	Idaho Department of Insurance	(208) 334-4250
Illinois	Illinois Department of Insurance	(217) 782-4515
Indiana	Indiana Department of Insurance	(317) 232-2385
Iowa	Division of Insurance	(515) 281-5705
Kansas	Kansas Department of Insurance	(785) 296-3071
Kentucky	Kentucky Office of Insurance	(502) 564-3630
Louisiana	Department of Insurance	(800) 259-5300
Maine	Maine Bureau of Insurance	(207) 624-8475
Maryland	Maryland Insurance Administration	(410) 468-2090
Massachusetts	Division of Insurance	(617) 521-7794
Michigan	Michigan Department of Insurance and Financial Services	(877) 999-6442
Minnesota	Minnesota Department of Commerce	(651) 539-1500
Mississippi	Mississippi Insurance Department	(800) 562-2957
Missouri	Missouri Department of Insurance, Financial Institutions and Professional Registration	(573) 751-3365
Montana	Montana Office of the Commissioner of Securities and Insurance	(406) 444-2040
Nebraska	Nebraska Department of Insurance	(402) 471-2201
Nevada	Nevada Division of Insurance	(775) 687-0700

STATE INSURANCE DEPARTMENT CONTACT LISTING

State	Insurance Department	Main Phone
New Hampshire	New Hampshire Department of Insurance	(603) 271-2261
New Jersey	New Jersey Department of Banking and Insurance	(609) 292-7272
New Mexico	Office of Superintendent of Insurance	(505) 827-4601
North Carolina	North Carolina Department of Insurance	(855) 408-1212
Ohio	Ohio Department of Insurance	(614) 644-2658
Oklahoma	Oklahoma Department of Insurance	(405) 521-2828
Oregon	Oregon Insurance Division Consumer Advocacy Unit	(503) 947-7984
Pennsylvania	Pennsylvania Department of Insurance	(717) 787-2317
Puerto Rico	Puerto Rico Department of Insurance	(787) 304-8686
Rhode Island	Rhode Island Insurance Division	(401) 462-9520
South Carolina	South Carolina Department of Insurance	(803) 737-6180
Tennessee	Tennessee Department of Commerce & Insurance	(615) 741-2241
Texas	Texas Department of Insurance	(800) 252-3439
Utah	Utah Department of Insurance	(801) 538-3800
Vermont	Vermont Division of Insurance	(802) 828-3301
Virginia	Virginia Bureau of Insurance	(804) 371-9741
Washington	Washington State Office of Insurance	(360) 725-7000
West Virginia	Offices of the Insurance Commission	(304) 558-3354
Wisconsin	Office of the Commissioner of Insurance	(608) 266-3585
Wyoming	Wyoming Department of Insurance	(307) 777-7401

BENEFITS AT A GLANCE

Life insurance provides financial protection for **your beneficiary** by paying a benefit in the event of **your** death. The amount **your beneficiary** receives is based on the amount of coverage in effect just prior to the date of **your** death according to the terms and provisions of the policy.

Accidental Death and Dismemberment insurance provides financial protection for **your beneficiary** by paying a benefit in the event of **your** accidental death or for **you** in the event of any other **covered loss**. The amount **you** or **your beneficiary** receives is based on the amount of coverage in effect just prior to the date of **your** accidental death or other **covered loss** according to the terms and provisions of the policy.

NAME OF EMPLOYER: GERRITY'S SUPERMARKET

POLICY NUMBER: 54433386

ELIGIBLE CLASS(ES):

ALL OTHER FULL TIME ACTIVE EMPLOYEES

You must be an **Employee** of the **Employer** and in an Eligible Class.

Temporary workers are excluded from coverage.

Seasonal workers are excluded from coverage.

Persons who are not legal residents or citizens of the United States are not eligible for coverage.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an Eligible Class, the date **you** are eligible for coverage is the later of:

1. the policy effective date; or
2. the day after **you** complete **your waiting period**.

WHEN COVERAGE BEGINS

Your Employer pays 100% of the cost of **your** coverage under the policy **(non-contributory insurance)**. For any amount of coverage that is not subject to **evidence of insurability**, **you** will be covered on the date **you** are eligible for such coverage. For any amount of coverage that is subject to **evidence of insurability, you** will be covered on the first day of the month following the date **we** approve **your enrollment form**.

When **you** and **your Employer** share the cost of **your** coverage under the policy (**contributory insurance**) or when **you** pay 100% of the cost yourself (**contributory insurance**), **you** will be covered on the latest of:

1. the date **you** are eligible for coverage, if **you enroll** for coverage on or before that date;
2. the first day of the month following the date **you enroll** for coverage, if **you enroll** within 31 days after the date **you** become eligible for coverage; or
3. the first day of the month following the date **we** approve **your enrollment form**, if **evidence of insurability** is required.

In order for **your** coverage to begin, **you** must be in **active employment**. **Your** coverage is subject to payment of full **premium** when due.

MINIMUM HOURS REQUIREMENT:

36 hours per week

WAITING PERIOD:

For persons in an Eligible Class on or before the policy effective date:
End of the month in which you complete a continuous period of 90 Day(s) of **active employment**.

For persons entering an Eligible Class after the policy effective date:
End of the month in which you complete a continuous period of 90 Day(s) of **active employment**.

REHIRE:

If **your** employment ends and **you** are rehired within 12 months **your** previous work while in an Eligible Class will apply toward the **waiting period**. All other policy provisions apply.

BENEFITS AT A GLANCE
LIFE INSURANCE

WHO PAYS FOR THE COVERAGE:

Basic Life insurance	
Employee Basic Life insurance:	**Your Employer** pays the cost of **your** coverage.

CONTINUATION OF LIFE INSURANCE AND WAIVER OF PREMIUM WHILE YOU ARE TOTALLY DISABLED ("WAIVER OF PREMIUM BENEFIT"):

Elimination period: 9 consecutive months

The elimination period begins on the first day of **your total disability**.

Waiver of Premium Benefits begin the day after **we** approve **your** claim and the elimination period is completed.

Maximum Benefit Period: To age 65

LIFE INSURANCE BENEFIT AMOUNT

Basic Life insurance	
Employee Basic Life insurance:	$10,000
Maximum Benefit Amount without **Evidence of Insurability**:	$10,000
Maximum Benefit:	$10,000

REDUCTION SCHEDULE:

Basic Life Insurance

If **you** have reached age 65, but not age 70, **your** amount of Life insurance will be:

1. 65% of the amount of Life insurance **you** had prior to age 65; or
2. 65% of the Life insurance benefit amount shown above if **you** become insured on or after age 65 but before age 70.

If **you** have reached age 70 or more **your** amount of Life insurance will be:

1. 50% of the amount of Life insurance **you** had prior to age 65; or
2. 50% of the Life insurance benefit amount shown above if **you** become insured on or after age 70.

If **your** Life insurance reduces based on the above schedule, there will be no further increases in **your** amount of Life insurance.

The reduction will take effect on the the Policy Anniversary Date coincident with or following the date **you** attain the age(s) as described above.

BENEFITS AT A GLANCE
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

WHO PAYS FOR THE COVERAGE

Basic AD&D Insurance	
Employee Basic AD&D insurance:	**Your Employer** pays the cost of **your** coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT ("AD&D") INSURANCE BENEFIT AMOUNT ("FULL AMOUNT")

Basic AD&D Insurance	
Employee Basic AD&D insurance:	$10,000
Maximum Benefit:	$10,000

ACCIDENTAL DEATH AND DISMEMBERMENT ("AD&D") INSURANCE BENEFIT AMOUNTS

ACCIDENTAL DEATH	BENEFIT AMOUNT
Loss of Life	The Full Amount

ACCIDENTAL DISMEMBERMENT COVERED LOSS	BENEFIT AMOUNT
Loss of Both Hands or Both Feet or Loss of Sight of Both Eyes	The Full Amount
Loss of One Hand and One Foot	The Full Amount
One Hand or One Foot and Loss of Sight Of One Eye	The Full Amount
Loss of Speech and Loss of Hearing in Both Ears	The Full Amount
Loss of One Hand or One Foot	One Half the Full Amount
Loss of One Leg or One Arm	One Half the Full Amount
Loss of Sight of One Eye	One Half the Full Amount
Loss of Speech or Hearing in Both Ears	One Half the Full Amount
Loss of Thumb and Index Finger of Same Hand	One-Quarter the Full Amount
Quadriplegia (total and irreversible paralysis of all four limbs)	The Full Amount
Triplegia (total and irreversible paralysis of three limbs)	Three-Quarters the Full Amount
Paraplegia (total and irreversible paralysis of both lower limbs)	Three-Quarters the Full Amount
Hemiplegia (total and irreversible paralysis of both limbs on either side of the body; i.e. the right arm and right leg or the left arm and left leg)	One Half the Full Amount
Uniplegia (total and irreversible paralysis of one limb)	One-Quarter the Full Amount

The most **we** will pay for any combination of **covered losses,** including death, from any one **accident** is the Full Amount.

Loss of a foot means that all of the foot is permanently severed at or above the ankle joint.

Loss of a hand means the hand is permanently severed from the body at or above the wrist, but below the elbow. Loss of a hand includes loss of the thumb and index finger of the same hand where the thumb and index finger are permanently severed through or above the metacarpophalangeal joints (i.e. the third joint from the tip of the finger and the second joint from the tip of the thumb.)

Loss of an arm means the arm is permanently severed at or above the elbow.

Loss of a leg means the leg is permanently severed at or above the knee.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 30 days following the date of loss.

Loss of sight means permanent and uncorrectable loss of sight in the eye, and that the visual acuity is 20/200 or worse in the eye or the field of vision is less than 20 degrees.

Loss of speech means the entire and irrecoverable loss of speech that continues for 30 days following the date of loss.

Loss of a thumb and index finger means the thumb and index finger of the same hand are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Paralysis means total and permanent impairment of voluntary movement and sensory function of a limb without severance. A **doctor** must determine the paralysis to be permanent, complete, and irreversible.

REDUCTION SCHEDULE:

Basic AD&D Insurance

The amount of **your** AD&D insurance will reduce by the same percentage and at the same time **your** Life insurance reduces.

If **your** AD&D insurance reduces based on the above schedule, there will be no further increases in **your** amount of AD&D insurance.

The reduction will take effect on the the Policy Anniversary Date coincident with or following the date **you** attain the age(s) as described above.

BENEFITS AT A GLANCE
ACCIDENTAL DEATH AND DISMEMBERMENT - OTHER BENEFITS

CHILD CARE EXPENSE BENEFIT

Maximum Annual Benefit Amount for each insured **child** who qualifies:

If an Accidental Death Benefit is paid due to **your** death:
The least of:
1. 5% of the Full Amount of **your** AD&D insurance amount;
2. $5,000; or
3. actual incurred child care expenses for the **child**.

Maximum Benefit Amount: $20,000, during the Maximum Benefit Period for each insured **child** who qualifies, regardless of the number of **children** who qualify.

Maximum Benefit Period: 5 consecutive year(s).

The Child Care Expense Benefit is payable only if an Accidental Death Benefit has been paid for the **insured person**. It is payable in addition to the Accidental Death Benefit.

CHILD EDUCATION EXPENSE BENEFIT

Maximum Per Academic Year Lump Sum Benefit Amount for each insured **eligible student**:

If an Accidental Death Benefit is paid due to **your** death:
The least of:
1. 5% of the Full Amount of **your** AD&D insurance amount;
2. $5,000; or
3. actual incurred tuition expenses.

Maximum Benefit Period:

The earlier of:

1. the date 4 lump sum Education Expense Benefits have been paid to **your eligible student**; or
2. the date ending 5 years following the date the first Education Expense Benefit was paid to **your eligible student**.

Maximum Lifetime Child Education Expense Benefits for each **eligible student**: $20,000.

The Child Education Expense Benefit is payable only if an Accidental Death Benefit has been paid for the **insured person**. It is payable in addition to the Accidental Death Benefit.

ELDER CARE EXPENSE BENEFIT

Maximum Lump Sum Benefit Amount

The lesser of:
1. 10% of the Full Amount of the **insured person's** AD&D insurance; or
2. $10,000.

The Elder Care Expense Benefit is payable only if an Accidental Death Benefit has been paid for the **insured person.** It is payable in addition to the Accidental Death Benefit.

REPATRIATION EXPENSE BENEFIT

Maximum Lump Sum Benefit Amount:

The lesser of:
1. $5,000; or
2. the actual expenses incurred.

The Repatriation Benefit is payable only if an Accidental Death Benefit has been paid for the **insured person**. It is paid in addition to the Accidental Death Benefit.

SEATBELT AND AIR BAG BENEFIT

Maximum Lump Sum Benefit Amount:

The Seatbelt Benefit is the lesser of:
1. 10% of the Full Amount of the **insured person's** AD&D insurance benefit amount; or
2. $10,000.

The Air Bag Benefit is the lesser of:
1. 5% of the Full Amount of the **insured person's** AD&D insurance benefit amount; or
2. $5,000.

The Seatbelt and Air Bag Benefit is payable only if an Accidental Death Benefit is payable for the **insured person**. It is payable in addition to the Accidental Death Benefit.

SPOUSE EDUCATION EXPENSE BENEFIT

If an Accidental Death Benefit is paid due to **your** death, the Maximum Per Academic Year Lump Sum Benefit Amount for **your spouse** is:

The least of:
1. 5% of **the** Full Amount of **your** AD&D insurance Benefit;
2. $5,000; or
3. the actual tuition expenses incurred.

Maximum Benefit Period:

The earlier of:

1. the date 4 lump sum Spouse Education Expense Benefits have been paid to **your spouse**; or
2. the date ending 5 years following the date the first Spouse Education Expense Benefit was paid to **your spouse**.

Maximum Lifetime Spouse Education Expense Benefits: $20,000.

The Spouse Education Expense Benefit is payable only if an Accidental Death Benefit has been paid on **your** life. It is payable in addition to the Accidental Death Benefit.

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

DEFINITIONS

ACCIDENT means a sudden, unexpected and unforeseeable, identifiable event resulting in bodily harm, directly produced by specific accidental contact with another body or object. The accident must occur while the insurance benefit for which a claim is being made is in force for the **insured person**.

ACCIDENTAL BODILY INJURY means bodily harm resulting solely from external, violent and accidental means and not contributed to by any other cause.

ACCREDITED INSTITUTION means any university, college or trade school, which is accredited by a regional accrediting agency that is recognized by the United States Department of Education.

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 regular occupation**. **You** must be working at least the minimum number of hours as described under the Minimum Hours Requirement in the BENEFITS AT A GLANCE.

To be in **active employment**, **your** work site must be:

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

We will consider **you** to be in **active employment** on weekends, holidays, and planned vacations that **your Employer** has approved in advance and during a temporary business closure not to exceed 15 days if **you** were in **active employment** on the last scheduled work day immediately prior to such time off. A temporary business closure includes a closure due to inclement weather, power outage or public health agency orders.

Temporary workers are excluded from coverage. Seasonal workers are excluded from coverage.

ANNUAL ENROLLMENT PERIOD means the 31 day period just prior to a Policy Anniversary Date.

APPROPRIATE CARE means that **you**:

1. visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s); and
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize **your** disabling condition including having corrective treatment or minor surgery.

BENEFICIARY means the person(s) to whom **we** will pay the Life insurance Benefit in accordance with the BENEFICIARY provision.

CERTIFICATEHOLDER means the person who is eligible for benefits provided by the **Policyholder's** policy and who has received a Certificate of Coverage.

CHANGE IN STATUS means a change in status as defined:

1. An **insured person's** marriage, or the birth or adoption of a **child**, or becoming the legal guardian of a **child**;
2. The death of or divorce from an **insured person's spouse**;
3. The death of or emancipation of a **child**;
4. **Spouse's** loss of employment which results in a loss of group insurance; or
5. Change in classification from part-time to full-time or from full-time to part-time.

CHILD means **your** biological/natural children, adopted children, stepchildren, children who are dependent on you for main support and living with you in a regular parent-child relationship, and any other children required to be covered under the civil union, domestic partnership, marriage, or other family or domestic relations **law** of the Governing Jurisdiction. A **child** will be considered adopted on the date of placement in **your** home.

If **you** reside in a State different from the Governing Jurisdiction of the policy, the Certificate of Coverage shall, if required, comply with the applicable civil union, domestic partnership, marriage or other family or domestic relations **law** of the State in which **you** reside.

CONTEST means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** assert in **writing** that such coverage was therefore never effective and any premium **you** paid is refunded to **you**. The **contest** is effective on the date **we** mail the letter. The **contest** is subject to time limits described in the Certificate of Coverage.

CONTRIBUTION means the amount the **Policyholder** may require an **insured person** to pay towards the total premium that **we** charge for the insurance provided under the policy.

CONTRIBUTORY INSURANCE means insurance for which the **Policyholder** requires the **insured person** to pay all or a portion of the **premium**. The Certificate of Coverage specifies who pays the cost of the coverage.

COVERED LOSS means loss of one or more of the body parts or bodily functions listed under the Accidental Dismemberment Covered Loss section in the BENEFITS AT A GLANCE. The term **covered loss** does not include loss of life.

DEPENDENT means **your spouse** and/or **child**.

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** or **your** family members, including but not limited to, **spouse**, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as **a doctor** for a claim that **you** send to **us**.

ELIGIBLE STUDENT means **your child** under the age of 26 who is attending an **accredited institution** beyond the 12th grade level on a full-time basis.

EMPLOYEE means a person who is in **active employment** with the **Employer** in the United States.

EMPLOYER means the **Policyholder** and includes any division, subsidiary, or affiliated company named in the policy.

For contributory insurance:

ENROLL means **you** have completed the process of applying for coverage under the policy.

ENROLLMENT FORM means the application, approved by **us**, **you** complete and submit to **us** to apply for coverage under the policy.

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage. **Evidence of insurability** will be provided at **our** expense**.**

EVIDENCE OF INSURABILITY FORM means the portion of the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history.

GRACE PERIOD means the 31 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder.**

HOSPITAL, HEALTH FACILITY OR INSTITUTION means an accredited facility licensed to provide care and treatment for the **total disability** or **covered loss**.

INJURY means an **accidental bodily injury** sustained by an **insured person** that is a direct result of an **accident**, independent of disease or bodily or mental illness or infirmity or any other cause. The **injury** must occur while the insurance benefit for which a claim is being made is in force for the **insured person**.

INSURED PERSON means a person who is eligible for the coverage under the policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

LAW, **POLICY**, or **ACT** means the original enactments of the law, plan, or act and all amendments.

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**. **Your** normal vacation time or any period **you** are not in **active employment** due to **sickness** or **injury** is not considered a **leave of absence**.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

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

NONCONTRIBUTORY INSURANCE means insurance for which the **Policyholder** does not require the **insured person** to pay any part of the **premium.** The Certificate of Coverage specifies who pays the cost of the coverage.

PAYABLE CLAIM means a claim for which **we** are liable under the terms of the policy.

POLICY MONTH means the month that begins on the effective date of the policy. Subsequent policy months will begin on the same day of each subsequent calendar month.

POLICYHOLDER means the **Employer** to whom the policy is issued and who sponsored the coverage for its **Employees**.

PREMIUM means the amount the **Policyholder** will pay to **us** for the insurance provided under the policy.

PROOF OF LOSS means **written** evidence of loss satisfactory to **us,** as described in the CLAIMS INFORMATION section.

REGULAR OCCUPATION means the occupation **you** are routinely performing when **your total disability** begins. **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 employer **or** at a specific location.

SICKNESS means an illness, disease or physical condition. **Total disability** resulting from the **sickness** must begin while **you** are covered under the policy.

SIGNED means any method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable **law**.

SPOUSE means **your** lawful spouse or any other person required to be covered as **your** spouse under the civil union, domestic partnership, marriage or other family or domestic relations **law** of the Governing Jurisdiction.

If **you** reside in a State different from the Governing Jurisdiction of the policy, the Certificate of Coverage shall, if required, comply with the applicable civil union, domestic partnership, marriage or other family or domestic relations **law** of the State in which **you** reside.

If it is not required by **law** to extend coverage under the policy to a domestic partner; however, **your Employer's** Human Resource Policy permits **you** to elect coverage for a domestic partner, **we** will recognize that person as a "spouse" under this policy, provided that **you** have completed and **signed** an affidavit or a declaration of domestic partnership on a form acceptable to **your Employer** and **us**.

Wherever in the Certificate of Coverage there is a reference to "divorce" or "divorced", it also means dissolution of a civil union, domestic partnership, or other family or domestic relations **law** of the Governing Jurisdiction.

Important: Federal **law** may impact how certain spousal rights and benefits within some insurance products are treated.

TERMINAL ILLNESS means a diagnosed illness that, according to generally accepted medical standards, is expected to result in death within 12 months.

TOTALLY DISABLED and **TOTAL DISABILITY** means that, due to **your sickness** or **injury**, **you** are unable to perform the **material and substantial duties** of **your regular occupation,** and **you** are unable to perform for pay or profit any other job for which **you** are reasonably qualified based on **your** training, education and experience.

WAITING PERIOD means the continuous period of time (shown in the BENEFITS AT A GLANCE) that **you** must be in **active employment** in an Eligible Class before **you** are eligible for coverage under the policy.

WE, **US**, and **OUR** means New York Life Insurance Company.

WRITTEN or **WRITING** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable **law**.

YOU and **YOUR** means an **Employee** who is eligible for coverage under the policy.

GENERAL PROVISIONS

ENTIRE CONTRACT

The insurance for **insured persons** is provided under a contract of group term Life insurance with the **Policyholder**, and the entire contract with the **Policyholder** consists of:

1. all policy provisions and any amendments and endorsements to the policy;
2. the Certificate of Coverage and any amendments and endorsements to the Certificate of Coverage;
3. the **Policyholder's signed** application; and
4. for **contributory insurance**, the **insured persons' signed enrollment forms**.

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a statement prepared by **us** and may include attachments. It tells **you**:

1. the coverage to which **you** may be entitled;
2. to whom **we** will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

We have **written your** Certificate of Coverage in understandable terms. However, a few terms and provisions are **written** as required by insurance **law**. If **you** have any questions about any of the terms and provisions, please consult **our** claims paying office. **We** will assist **you** in any way to help **you** understand **your** benefits.

POLICY CHANGES

The policy may be changed. Only an officer or registrar of New York Life 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 this policy or waive any part of it. A copy of any amendment or endorsement issued will be provided to the **Policyholder** for attachment to the policy and will also be provided to the **certificateholder** if the change affects the Certificate of Coverage.

DATES

For purposes of effective dates and ending dates under the Certificate of Coverage, all days begin at 12:01 a.m. Standard Time at the **Policyholder's** address and end at 12:00 midnight Standard Time at the **Policyholder's** address.

LATE APPLICANT ENROLLMENT REQUIREMENTS - IF YOU APPLY FOR COVERAGE MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE (for contributory insurance plans)

You can apply for coverage during an **annual enrollment period**, or within 31 days of a **change in status**. **Evidence of insurability** is required for any amount of coverage.

WHEN CHANGES TO COVERAGE BECOME EFFECTIVE

Changes in coverage made during an **annual enrollment period** will be effective on the later of the Policy Anniversary Date following the **annual enrollment period**, or the date **we** approve **your enrollment form,** if **evidence of insurability** is required.

A change in coverage due to a **change in status** will begin on the latest of:

1. the date of the **change in status**, if **you** apply on or before that date;
2. the date **you** apply, if **you** apply within 31 days after the date of the **change in status**; or
3. the date **we** approve **your enrollment form**, if **evidence of insurability** is required.

Changes in coverage must be appropriate and consistent with the **change in status**.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of Insurability is required if:

1. **you** are a late applicant, which means **you enroll** for coverage more than 31 days after the date **you** are eligible for coverage;
2. **you** canceled **your** coverage and are reapplying;
3. **you** apply for a benefit amount greater than the Maximum Benefit Amount without Evidence of Insurability as shown in the BENEFITS AT A GLANCE; or
4. **you** apply to increase **your** coverage by any amount during the policy year.

If **you** are not approved for an increase in **your** coverage, **you** will automatically remain at the same level of coverage **you** had prior to applying for the increase.

An **evidence of insurability form** can be obtained from **your Employer**.

WHEN COVERAGE ENDS

Your coverage under the policy ends on the earliest of:
1. the date the policy is canceled;
2. the date **you** are no longer in an Eligible Class;
3. the date **your** Eligible Class is no longer covered;
4. the end of the period for which **you** paid **premiums**, if **you** stop making a required **premium contribution**;
5. the end of the **Policyholder's grace period** if the **Policyholder** does not remit **premium** to **us** by the end of such period;
6. the date **you** voluntarily cancel **your** coverage under the policy in **writing**, as permitted by **Policyholder;**
7. the date **you** retire;
8. the last day **you** are in **active employment,** except as provided under the CONTINUATION OF LIFE INSURANCE section of the Certificate of Coverage; or
9. the date of **your** death.

If coverage under the policy ends, this shall not prejudice payment for an eligible benefit due to an **accident** that occurred while **you** are insured under the policy prior to the date **your** coverage ends.

If coverage under the policy ends, **insured persons** may be eligible to convert group term Life insurance to an individual policy, subject to the terms of the CONVERSION TO AN INDIVIDUAL LIFE POLICY provision.

LEGAL ACTION

You can start legal action regarding **your** claim 60 days after **proof of loss** has been given to **us** and not later than the date established by the applicable insurance **law** in the state where the policy was issued, unless otherwise provided under federal **law**.

INCONTESTABILITY

We consider any statements made by an **insured person** a representation and not a warranty. No statement made by an **insured person** will be used to reduce or deny any claim or to cancel an **insured person's** coverage unless:

1. the statement is in **writing** on an **enrollment form** or **evidence of insurability form** that is **signed** by the **insured person**; and
2. a copy of that statement is given to the **insured person**, the **beneficiary** or legally authorized representative.

No statement made by an **insured person** relating to his or her insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years. For any applied for increases in coverage or reinstatement of coverage, a new two year contestability period is applicable to the amount of the applied

for increase or reinstated coverage. Fraudulent statements will be used to **contest** the insurance for which the fraudulent statement was made when permitted by applicable **law**.

No statement will be used to **contest** the insurance under the policy unless the statement is material to the risk accepted by **us**.

MISSTATEMENT OF AGE

If an **insured person's** age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust the **premium** and/or benefits. If the **premium** is based on age, **we** will adjust the **premium**. If the benefits are based on age, **we** will adjust the benefits.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy 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 **our** agent.

LIFE INSURANCE CONTINUATION

CONTINUATION OF LIFE INSURANCE

IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence**, and if all **premium** is paid when due, **your** Life insurance may be continued beyond the date **you** are no longer in **active employment**, limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of Life insurance during an FMLA or State FML **leave of absence**, **your** Life insurance will be continued until the end of 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**.

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if all **premium** is paid when due, **you** may be covered through the end of the month that immediately follows 1 month after the date **you** stopped **active employment**.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law**, **your** Life insurance may be continued until the end of the later of:

1. the length of time the insurance may be continued under the policy for an FMLA or State FML **leave of absence**; or
2. the length of time the insurance may be continued under the policy for a **leave of absence** other than an FMLA or State FML **leave of absence**.

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment**, **we** will consider such leaves to be concurrent for the purpose of determining how long **your** Life insurance may continue under the policy.

If **your** Life insurance is not continued during an FMLA or State FML **leave of absence**, and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence**, **your** Life insurance will be reinstated. **We** will not apply a new **waiting period** or require **evidence of insurability**.

If **your** Life insurance is not continued during a **leave of absence** for active military service, and **you** return to **active employment**, **your** Life insurance may be reinstated in accordance with USERRA and applicable state **law**.

IF YOU ARE NOT WORKING DUE TO SICKNESS OR INJURY AFTER YOUR COVERAGE BEGINS

If **you** are not in **active employment** due to **your sickness** or **injury**, and if all **premium** is paid when due, **you** may continue **your** Life insurance for 12 months after **your** last day of **active employment**. **Premium** for the continuation period must be paid on the same basis as **premium** was paid on the day before **your sickness** or **injury** began. Continuation shall be provided for **your** Life insurance that was in force under the policy on the day before **your sickness** or **injury** began.

If **your** Life insurance is continued under the policy due to **your sickness** or **injury** or any other reason as described above, **you** may continue **your dependent** Life insurance under the policy, provided all **premium** is paid when due.

If **your** Life insurance is continued, **you** may also continue **your** AD&D insurance for up to 12 months after **your** last day of **active employment**, provided all **premium** is paid when due.

While covered under this provision, coverage will reduce according to the REDUCTION SCHEDULE as shown in the BENEFITS AT A GLANCE.

If **you** return to **active employment** in an Eligible Class following a period of continuation, **your** insurance will continue subject to the terms of the policy. If **you** do not return to **active employment** following a period of a continuation, **you** will end according to the WHEN COVERAGE ENDS provision.

If **you** die during the continuation period, **we** will pay the death benefit to the **beneficiary** upon receipt of **proof of loss** establishing that **you** died during the continuation period.

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN COVERAGE ENDS provision.

If at the end of a continuation period and if eligibility for coverage under the policy ends, the terms of the CONVERSION TO AN INDIVIDUAL LIFE POLICY provision apply.

CONTINUATION OF LIFE INSURANCE AND WAIVER OF PREMIUM WHILE YOU ARE TOTALLY DISABLED "WAIVER OF PREMIUM BENEFIT")

Your Life insurance may be continued for a specific time and **your** Life insurance **premium** will be waived if **you** qualify as described below.

You must be **totally disabled** through **your** elimination period. **Your** elimination period is as stated in the BENEFITS AT A GLANCE and is the period of continuous **total disability you** must satisfy.

IMPORTANT NOTICE: The **Policyholder** may continue **premium** payments until **we** notify the **Policyholder** of the date **your** Life insurance **premium** waiver begins, or **you** may convert to an individual policy under the CONVERSION TO AN INDIVIDUAL LIFE POLICY provision. For insurance to continue under the group policy, full **premium** when due is required.

Your Life insurance **premium** waiver will begin when **we** approve **your** claim, if the elimination period has ended, and **you** meet the following conditions:

1. **you** are less than 60 years old and insured under the policy on the date **you** become **totally disabled**;
2. **you** remain **totally disabled** during the elimination period;
3. **you** meet the notice and **proof of loss** requirements for **total disability**, as described in the CLAIM INFORMATION section of the policy, while **your** Life insurance is in effect; and
4. **your** claim is approved by **us**.

We will send **you written** notice advising whether **you** are approved for the Waiver of Premium Benefit and, if approved, the amount of **premium** being waived. If **we** approve **your** claim, **we** will not require further **premium** payments for **you** while **you** remain **totally disabled** according to the terms and provisions of the policy. **Your** Life insurance amount will not increase while **your** Life insurance **premiums** are being waived. **Your** Life insurance amount will reduce or cease at any time it would reduce or cease if **you** had not been **totally disabled**.

If **you** die during the elimination period and are otherwise eligible for this WAIVER OF PREMIUM BENEFIT, the elimination period will not apply. Benefits for loss of life will be paid according to the CLAIM INFORMATION section of the policy.

Premiums waived under this provision will not be deducted from any benefits paid under the policy.

WHEN YOUR WAIVER OF PREMIUM BENEFIT ENDS

Your Waiver of Premium Benefit will automatically end on the earliest of the following:
1. the date **you** are no longer **totally disabled**;
2. the date **you** fail to submit proof of continuing **total disability**;
3. the end of the Maximum Benefit Period shown in the BENEFITS AT A GLANCE; or
4. the date **you** die.

If **your** coverage under the WAIVER OF PREMIUM BENEFIT provision ends, and **you** do not immediately return to **active employment** in an Eligible Class and become insured under the policy, **you** may convert **your** coverage as described under the CONVERSION TO AN INDIVIDUAL LIFE POLICY provision.

EXTENSION OF BENEFITS

Your insurance will continue under the WAIVER OF PREMIUM BENEFIT provision even if the policy ends, if **you** meet the proof requirements as stated in the CLAIM section of the **policy**. In no event will it continue beyond when it would otherwise end according to the WHEN YOUR WAIVER OF PREMIUM BENEFIT ENDS provision.

LIFE INSURANCE CONVERSION

CONVERSION TO AN INDIVIDUAL LIFE POLICY

You can convert **your** group Life insurance to an individual Life policy, without **evidence of insurability**, if:

1. **you** are no longer in an Eligible Class;
2. **you** end **active employment** with the **Employer**;
3. **your** coverage under the CONTINUATION OF LIFE INSURANCE provision ends;
4. **you** are not eligible for Portability coverage**;**
5. **your** Portability coverage, if any, ends;
6. the group policy ends; or
7. the policy is changed to end Life insurance for the Eligible Class to which **you** belong.

You can convert **your** group Life insurance that ends due to a reduction of Life insurance that is due to:

1. attaining a specified age;
2. **your** changing from one Eligible Class to another; or
3. due to a **policy** or plan change.

If an **insured person's** group Life insurance ends because the group policy has been cancelled, and the **insured person** becomes covered under any other group Life policy within 31 days after the date the policy is cancelled, the right to convert is not available to that **insured person**.

If **you** convert to an individual Life policy, then return to work, and, again, become insured under the policy, **you** are not eligible to convert to an individual Life policy again. However, **you** do not need to surrender that individual Life policy when **you** return to work.

AMOUNT OF CONVERSION COVERAGE

The maximum amount that an **insured person** can convert is the amount of group Life insurance that ended due to one of the reasons stated in the above provision, less the amount of group Life insurance for which the **insured person** becomes eligible under any group policy or plan within 31 days after the date the **insured person's** coverage ended or was reduced under this policy. An **insured person** may convert a lower amount of group Life insurance. If an **insured person** converts a lower amount of group Life insurance, the **insured person** will not have the right to increase the amount of the individual Life insurance at a later date.

APPLYING FOR CONVERSION COVERAGE AND NOTICE OF CONVERSION RIGHT

To apply for Conversion coverage, **insured persons** must apply and pay the first **premium** within 31 days after the date:

1. **you** become eligible for conversion insurance; or
2. **the insured person** is no longer eligible to participate in the coverage of the group policy.

The **Policyholder** must provide **written** notice of the Conversion right at least 15 days prior to the date Life insurance ends or is reduced. The right to convert will expire on the later of 16 days after **you** are given such notice or the end of the 31 day conversion application period, but in no event will the right to convert extend beyond 60 days after the expiration of the conversion application period. The notice will be mailed to **your** last known address and will constitute notice of the right to convert.

During the conversion application period, the **insured person's** Life insurance will continue under the terms of the Certificate of Coverage. This coverage is available whether or not the **insured person** has applied for an individual Life policy under the Conversion privilege.

INDIVIDUAL LIFE CONVERSION POLICY

The individual Life conversion policy may be any form then customarily offered by **us**, except individual term Life insurance. The individual Life conversion policy will not contain disability or other extra benefits.

The individual Life conversion policy will be effective on the day after the conversion application period ends.

The Incontestability and Life Insurance Suicide Exclusion provisions will apply to Conversion coverage and will run from the date of the **insured person's** effective date of coverage under the policy. If the Conversion coverage includes additional coverage for which **evidence of insurability** was provided, new Incontestability and Life Insurance Suicide Exclusion provisions may apply to the Conversion coverage.

PREMIUMS FOR THE INDIVIDUAL LIFE CONVERSION POLICY

The **premiums** for the individual Life conversion policy will be based on **our** rates then in use, the form and amount of coverage, the **insured person's** class of risk, and the **insured person's** attained age when coverage ended or reduced under the group policy.

DEATH DURING THE CONVERSION APPLICATION PERIOD

If the **insured person** dies within the 31 day conversion application period, **we** will pay the **beneficiary** the amount of Life insurance that could have been converted, exclusive of any additional benefits. Any **premium** that was paid for an individual Life conversion policy will be refunded to the **beneficiary** of the group policy. If application and **premium** payment has been made for the individual Life conversion policy, any **premiums** paid for the individual Life conversion policy will be refunded. In no event will **we** be liable to pay a death benefit under both the group policy and the individual Life conversion policy.

If **you** apply for Portability and **your** application for Portability coverage is not approved by **us,** and if **you** die during the 31 day conversion application period, **we** will pay the **beneficiary** the amount of Life insurance that could have been converted. Any **premium** that was paid for Portability coverage will be refunded to the **beneficiary** of the group policy under which **you** were insured at the time **you** became eligible for Conversion coverage. In no event will **we** be liable to pay a death benefit for both the Life insurance **you** are entitled to convert and the Life insurance **you** are entitled to continue under the Portability provision.

LIFE INSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
BENEFIT INFORMATION

LIFE INSURANCE BENEFIT

When **we** receive **written** proof that an **insured person** has died, **we** will pay the amount of that **insured person's** Life insurance to the **beneficiary**. **We** will pay it in a single sum unless an optional payment method is chosen.

We will determine the payment according to the amount of insurance shown in the BENEFITS AT A GLANCE.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

When **we** receive **written** proof that an **insured person** has died as a result of an **accidental bodily injury**, **we** will pay the amount of that **insured person's** Accidental Death Benefit to the **beneficiary**. **We** will pay it in a single sum unless an optional payment method is chosen.

If an **insured person** suffers one or more of the **covered losses** shown in the BENEFITS AT A GLANCE as the direct result of an **accidental bodily injury**, **we** will pay a benefit to the **insured person**.

We will determine the payment according to the **covered losses** and benefits shown in the BENEFITS AT A GLANCE.

The Accidental Death and Dismemberment Benefit will be paid only if:

1. the **insured person's** death occurs within 365 days from the date of the **accident**; or
2. the **accidental bodily injury(ies)** results in one or more of the **covered losses** within 365 days from the date of the **accident**.

Also, the **accident** must occur while the person is insured under the policy.

The most **we** will pay for any combination of **covered losses**, including loss of life, from any one **accident** is the Full Amount.

The Full Amount is the amount shown in the BENEFITS AT A GLANCE.

ACCELERATED DEATH BENEFIT

If an **insured person** is **terminally ill** while insured under the policy, **we** will pay **you** a portion of the **insured person's** Life insurance benefit one time. The payment will be based on 50% of the **insured person's** Life insurance amount. However, the one-time benefit paid will not exceed the lesser of the maximum Life insurance benefit available under the policy or $500,000**.**

Your right to exercise this option and to receive payment is subject to all of the following:

1. **you** request this election, in **writing**, on a form acceptable to **us**;
2. the **insured person** must be **terminally ill** at the time of payment of the Accelerated Death Benefit;
3. the **insured person's doctor** must certify, in **writing**, that the **insured person** has a **terminal illness**; and
4. the **doctor's** certification must be deemed satisfactory to **us**.

We may require a second or third medical opinion to confirm **your** eligibility for the Accelerated Death Benefit, which will be at **our** expense. The second medical opinion may include a physical examination by a **doctor** designated by **us**. If the medical opinions of the two **doctors** conflict, **your** eligibility for the Accelerate Death Benefit will be determined by the medical opinion of a third **doctor** who is mutually acceptable to **you** and to **us**.

The Accelerated Death Benefit payment will be made to **you** immediately upon receipt of such due **written** proof. Upon **your** request for an Accelerated Death Benefit and at the time of payment, **we** will notify **you** and any assignee of record or irrevocable **beneficiary** of record, in writing, of the effect that receipt of the Accelerated Death Benefit will have on **your** life insurance benefit and **premium**.

Accelerated Death Benefits are available on a voluntary basis. Therefore, **you** are not eligible for benefits if:

1. **you** are required by **law** to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
2. **you** are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Your premium amount will not change and **premium** payments must continue to be paid on the full amount of **your** Life insurance unless **you** qualify to have **your** life **premium** waived.

If **you** have assigned **your** rights under the policy to an assignee or made an irrevocable **beneficiary** designation, **we** must receive consent, in **writing**, that the assignee or irrevocable **beneficiary** has agreed to the Accelerated Death Benefit payment on **your** behalf in a form acceptable to **us** before benefits are payable.

An election to receive an Accelerated Death Benefit will have the following effect on other benefits:

1. the death benefit payable will be reduced by any amount of Accelerated Death Benefit that has been paid; and
2. any amount of Life insurance that would be continued under the WAIVER OF PREMIUM BENEFIT provision or that may be available under CONVERSION TO AN INDIVIDUAL LIFE POLICY provision will be reduced by the amount of the Accelerated Death Benefit paid.

The remaining Life insurance amount will be paid according to the terms of the policy subject to any reduction and termination provisions.

If **you** die after an Accelerated Death Benefit is elected, but before payment of such benefit is received, the election shall be cancelled and the death benefit will be paid according to the terms of the policy.

Eligibility for an Accelerated Death Benefit will end on the date **your** coverage under the policy ends, according to the terms of the WHEN COVERAGE ENDS provision. Such termination will not affect payment of a benefit if eligibility occurred while **your** coverage was in effect.

Benefits paid may be taxable. **We** are not responsible for any tax or other effects of any benefit paid. As with all tax matters, **you** should consult **your** personal tax advisor to assess the impact of this benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
OTHER BENEFITS

CHILD CARE EXPENSE BENEFIT

If **you** die as a result of an **accidental bodily injury** for which an Accidental Death Benefit is paid under this policy, **we** will pay an additional Child Care Expense Benefit on behalf of each **child** an annual Child Care Expense Benefit if proof is furnished to **us** that child care expenses are being incurred for the **child**.

For the benefit to be paid, the child care must be care or supervision of **your child** provided by a licensed Child care center or a licensed caregiver who is not related to **you** by blood or marriage.

The Child Care Expense Benefit amount and Maximum Benefit Period are shown in the BENEFITS AT A GLANCE.

The Child Care Expense Benefit will end for each **child** on the earliest of the following dates:

1. the date **your** legally authorized representative fails to furnish proof as required by **us**;
2. the date **your child** no longer qualifies as a **dependent child** for any reason except **your** death; or
3. the date the Child Care Expense Maximum Benefit Period ends.

CHILD EDUCATION EXPENSE BENEFIT

If **you** die as a result of an **accidental bodily injury** for which an Accidental Death Benefit is paid under this policy, **we** will pay an additional Child Education Expense Benefit on behalf of each **child** who is an **eligible student** at the time of **your** death. The Education Expense Benefit will be paid to **your** legally authorized representative on behalf of **your eligible student**.

The Child Education Expense Benefit amount and Maximum Benefit Period are shown in the BENEFITS AT A GLANCE.

In addition to the **proof of loss** requirements stated in the CLAIM INFORMATION section, **proof of loss** for the Child Education Expense Benefit, provided at the claimant's legally authorized representative's expense, must also show:

1. the date of enrollment of **your eligible student**;
2. the name of the **accredited institution**;
3. a list of courses for the current academic term;
4. the number of credit hours for the current academic term; and
5. proof that **your eligible student** completed the academic term.

The Child Education Expense Benefit will end for each **eligible student** on the earliest of the following dates:

1. the date **your eligible student** fails to furnish proof as required by **us**;
2. the date **your eligible student** no longer qualifies as a **dependent child** for any reason except **your** death; or
3. the date the Child Education Expense Benefit Maximum Benefit Period ends.

ELDER CARE EXPENSE BENEFIT

We will pay an additional Elder Care Expense Benefit if the **insured person** dies from an **accidental bodily injury** for which an Accidental Death Benefit is paid under this policy and at the time of the **insured person's** death, a **relative** is dependent on the **insured person** for **elder care.**

Relative means at the time of the **insured person's** death a **spouse**, sibling, parent, or grandparent of the **insured person,** who is age 65 or older was dependent on the **insured person** for **elder care.**

Elder Care means the **insured person** is providing support and maintenance either by providing the **relative** residence in the **insured person's** home or by paying partial or full assisted living, nursing home, home health care or adult day care expenses for the **insured person's relative.**

The Elder Care Expense Benefit amount and Maximum Benefit Period are shown in the BENEFITS AT A GLANCE.

In addition to the **proof of loss** requirements stated in the CLAIM INFORMATION section, **proof** of **loss** for the Elder Care Expense Benefit, provided by the **insured person's beneficiary** must include proof that prior to the **insured person's** death:

1. the **relative** resided with the **insured person**; or
2. the **insured person** paid for the **relative's** assisted living, nursing home, home health care or adult day care expenses.

REPATRIATION BENEFIT

We will pay an additional benefit of up to $5,000 for the preparation and transportation of an **insured person's** body to a mortuary chosen by the **insured person's** legally authorized representative. Payment will be made if, as the result of a covered **accident**, the **insured person** suffers an accidental death at least 75 miles away from the **insured person's** principle place of residence.

SEATBELT(S) AND AIR BAG BENEFIT

We will pay **you** or **your** legally authorized representative an additional benefit if **you** sustain an **accidental bodily injury** which causes **your** death while **you** were driving or riding in a **private passenger vehicle**, provided:

For Seatbelt(s):

1. the **private passenger vehicle** was equipped with seatbelt(s);
2. the seatbelt(s) were in actual use and properly fastened at the time of the covered **accident**; and
3. the position of the seatbelt(s) are certified in the official report of the covered **accident**, or by the investigating officer.

A copy of the police accident report must be submitted with the claim. If such certification is not available, and it is clear that **you** were properly wearing a seatbelt(s), then **we** will pay the additional seatbelt benefit. If such certification is not available, and it is unclear whether **you** were properly wearing a seatbelt(s), then **we** will pay a fixed benefit of $1,000.

We will only pay the seatbelt benefit for the death of a minor, **dependent child**, if the **child** was correctly strapped and fastened in the appropriate seat for the **child's** age and weight as defined by state or federal guidelines. The seatbelt device must also be approved by the state or federal government for the **dependent child's** age and weight.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

1. the **private passenger vehicle** is equipped with an airbag for the seat in which **you** are seated; and
2. the seatbelt(s) must be in actual use and properly fastened at the time of the **accident**.

Private passenger vehicle means a validly registered four-wheel private passenger vehicle.

No benefit will be paid if **you** were the driver of the **private passenger vehicle** and did not hold a current and valid driver's license.

No benefit will be paid if **we** are able to verify that the airbag(s) had been disengaged prior to the **accident**.

SPOUSE EDUCATION EXPENSE BENEFIT

We will pay a Spouse Education Expense Benefit to **your** surviving insured **spouse** if:

1. **you** die as a result of an **accidental bodily injury**; and
2. **your spouse** is not working in any capacity for wage or profit on the date of **your accident**; and

3. **your spouse enrolls** in an **accredited institution** for the purpose of obtaining an independent source of support and maintenance.

The Spouse Education Expense Benefit amount and Maximum Benefit Period are shown in the BENEFITS AT A GLANCE.

In addition to the **proof of loss** requirements stated in the CLAIM INFORMATION section, **proof of loss** for the Spouse Education Expense Benefit, provided at **your spouse's** expense, must also show:

1. the date of enrollment of **your spouse**;
2. the name of the **accredited institution**;
3. a list of courses for the current academic term;
4. the number of credit hours for the current academic term; and
5. proof that **your spouse** completed the academic term.

The Spouse Education Expense Benefit will end for **your spouse** on the earliest of the following dates:

1. the date 4 lump sum Spouse Education Expense Benefits have been paid to **your spouse**; or
2. the date ending 5 years following the date the first Spouse Education Expense Benefit was paid to **your spouse**; or
3. the date **your spouse** fails to furnish proof as required by **us.**

EXCLUSIONS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT EXCLUSIONS

The policy does not cover:

1. loss caused or contributed to by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity;
2. an infection not occurring as a direct result or consequence of **accidental bodily injury**;
3. loss caused or contributed to by attempted suicide, while sane or insane;
4. loss caused or contributed to by intentionally self-inflicted harm, while sane or insane;
5. loss caused or contributed to by travel in or descent from an aircraft, if the **insured person** acted in a capacity other than as a passenger;
6. loss caused or contributed to by travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, used for travel beyond the earth's atmosphere;
7. loss caused or contributed to by war or act of war;
8. loss caused or contributed to by active participation in a riot, insurrection, or terrorist activity;
9. loss occurring while an **insured person** is incarcerated;
10. loss caused or contributed to by committing or attempting to commit a felony;
11. loss caused or materially contributed to by voluntary intake or use by any means of:
    a. any drug, unless:
        i. prescribed or administered by a **doctor** and taken in accordance with the **doctor's** instructions; or
        ii. an over the counter drug, taken in accordance with the instructions.
    b. any poison, gas or fumes, unless a direct result of an occupational accident; and
12. loss caused or contributed to being intoxicated as defined by the jurisdiction where the **accident** occurred.

CLAIM INFORMATION

NOTICE OF CLAIM

Written notice of a claim should be given to **us** within 30 days after the date of the loss. The notice may be given to **us** at **our** home office or to **our** authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

FILING A CLAIM

If the claim is for loss of life, when **we** receive notice of a claim, **we** will send the **beneficiary** or legally authorized representative certain claim form(s). If the **beneficiary** or legally authorized representative does not receive the claim form(s) within 15 days, **we** will accept a **written** description of the exact nature of the loss.

If the claim is related to **your total disability**, the claim form is available from the **Policyholder**, or **you** can request a claim form from **us**. If **you** or **your** legally authorized representative do not receive the form from **us** within 15 days of the request for the form, **you** may send **us proof of loss** on any form sufficient to provide **us** with **proof of loss**. **Your Employer** must fill out the claim form and then give it to **your** attending **doctor**. **Your doctor** should fill out his or her section of the form and send it directly to **us**.

If the claim is for any other benefit provided under the policy, the claim form is available from the **Policyholder**, or **you**, the **beneficiary**, or legally authorized representative can request a claim form from **us**. If the form is not received from **us** within 15 days of the request for the form, **we** will accept **proof of loss** on any form sufficient to provide **us** with **proof of loss**. Depending on the nature of the claim, **your Employer** and/or **the insured person's doctor** may be required to provide **us** with information.

PROOF OF LOSS IN THE EVENT OF DEATH

We will require a certified copy of the death certificate of the **insured person**, or other lawful evidence providing equivalent information, and proof of the **beneficiary's** interest in the proceeds. **Proof of loss** provided at the **beneficiary's** or legally authorized representative's expense must show the cause of death.

PROOF OF LOSS IN THE EVENT OF A TOTAL DISABILITY

You must send **us written** proof of **your** loss within 90 days after the end of the elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. **You** must provide **proof of loss** no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of loss, provided at **your** expense, must show:

1. that **you** are under the **appropriate care** of a **doctor**;
2. the date **your total disability** began;
3. the cause of **your total disability**;
4. that **you** have been **totally disabled** through **your** elimination period;
5. the appropriate documentation of **your** earnings and **your** activities;
6. the extent of **your total disability**, including restrictions and limitations; and
7. the name and address of any **hospital**, **health facility** or **institution** where **you** received treatment, including all attending **doctors**.

After **we** approve **your** claim of **total disability, we** may periodically request proof of continuing **total disability. We** will not request proof of continuing **total disability** more frequently than once every six months.

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 **your proof of loss**, or proof of continuing **total disability**.

You or **your Employer** must notify **us** immediately when **you** return to work in any capacity.

PROOF OF LOSS IN THE EVENT OF ACCIDENTAL DEATH AND DISMEMBERMENT

If the claim is based on an accidental death and dismemberment **covered loss**, **proof of loss** for **covered loss**, provided at the claimant or legally authorized representative's expense, must show:

1. the cause of death or **covered loss**;
2. the extent of **covered loss**;
3. the date of **covered loss**; and
4. the name and address of any **hospital, health facility** or **institution** where treatment was received, including all attending **doctors**.

PAYMENT OF CLAIMS

When **we** receive **proof of loss**, **we** will review the **proof of loss** and, if **we** approve the claim, **we** will pay the benefit(s) subject to the terms of the policy.

If a claim is based on death, once the claim is approved, **we** will pay it in one lump sum to the **beneficiary.**

The Child Care Expense Benefit will be paid to **you**, if living; otherwise, it will be paid to **your** legally authorized representative.

The Child Education Expense Benefit will be paid to **your eligible student** or the **eligible student's** legally authorized representative.

The Elder Care Expense Benefit will be payable to the **insured person's** dependent **relative**, otherwise the **insured person's beneficiary**.

The Repatriation Benefit will be paid to the **insured person's** legally authorized representative.

The Seatbelt(s) and Airbag Benefit will be paid to **you if living, otherwise your** legally authorized representative.

The Spouse Education Expense Benefit will be paid to **your** surviving insured **spouse**.

Unless otherwise indicated, benefits will be paid to **you**.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of **your** death up to the date of payment. The minimum interest rate payable will be the interest at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve applicable for funds left on deposit with **us** as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

1. the date **we** receive due **proof of loss** following death.
2. the date **we** receive sufficient information to determine **our** liability, the extent of **our** liability, and the appropriate payee legally entitled to the proceeds.
3. the date that legal impediments to payment of proceeds that depend on the action of parties other than **us** are resolved and sufficient evidence of this resolution is provided to **us**. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

AUTHORITY

The **Policyholder** has delegated authority to the insurance company or its designee and understands that the insurance company or its designee reserves the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and certificate for the purpose of administering the terms of the policy and certificate.

REVIEW OF DENIAL OF CLAIMS

If **your** claim is denied, **you** have the right to notify **us** in **writing** within 90 days of receiving notice of the denial that **you** would like **us** to review the denial.

Upon request, **you** have the right to review copies of all documents, records, and other information relevant to **your** claim free of charge. **You** may submit **written** comments, documents, records and other information relating to **your** claim that **you** would like **us** to consider in reviewing **your** denial.

We will review the denial of **your** claim and send **you** notice of **our** decision within 60 days of receiving **your** request. If **we** require an extension of the deadline to obtain more information, **we** will give **you** notice of **our** decision within 60 days after the end of the extension period. **Our** decision will state the reasons for **our** decision, refer to the relevant portions of **your** certificate and advise **you** of any further appeal rights.

OVERPAID CLAIMS

We have the right to recover any overpayments due to fraud or any administrative error **we** make in processing a claim.
We will determine the method by which the repayment is to be made. **We** will not recover more money than the amount **we** overpaid.

PHYSICAL EXAMINATION AND AUTOPSY

In case of death, **we** reserve the right to make a reasonable request for an autopsy at **our** expense where permitted by **law**.

In case of **total disability or** other **covered loss, we** may require **you** to be examined by one or more **doctors** or other medical practitioners of **our** choice. **We** will pay for this examination. **We** can require an examination as often as it is reasonable to do so during the pendency of a claim. **We** may also require **you** to be interviewed by **our** representative. **Your** failure to comply with this request may result in denial of benefits.

BENEFICIARY DESIGNATION

At the time **you** become insured, **you** should name a **beneficiary** on a form acceptable to **us** for **your** death benefits under **your** Life insurance. The form is available through **your Employer**. **You** may change **your beneficiary** at any time by filing a form acceptable to **us**. Unless otherwise specified by **you**, the new **beneficiary** designation will be effective as of the date **you signed** that form, subject to any payments made or actions taken by **us** prior to receipt of the notice of change in **beneficiary**.

It is important that **you** name a **beneficiary** and keep **your** designation current. If more than one **beneficiary** is named and **you** do not designate their order or share of payments, the **beneficiaries** will share equally. The share of a **beneficiary** who dies before **you**, or the share of a **beneficiary** who is disqualified, will pass to any surviving **beneficiaries** in the order **you** designated. If **you** do not name a **beneficiary**, **we** have the right to make payment to the surviving family members in the order listed below:

1. **spouse**;
2. **child** or **children**;
3. mother or father;
4. sisters or brothers; or
5. **your** estate.

If **you** designate an irrevocable **beneficiary**, such **beneficiary** designation cannot be changed without the consent of the irrevocable **beneficiary**.

Any application for conversion that names a **beneficiary** that is different from the last **beneficiary** named under the group policy will be considered a change of **beneficiary** to the person(s) named in the conversion application. The change will be effective as of the date the conversion application form is **signed**, subject to any payments made or actions taken by **us** prior to receipt of the conversion application.

If an **insured person** dies during the conversion application period, and a different **beneficiary** is named for the conversion coverage, that different **beneficiary** will not be paid. If **you** want to name a different **beneficiary** for **your** group insurance, **you** must change **your beneficiary** as described above.

If **we** are to make payments to a **beneficiary** who lacks the legal capacity to give **us** a release, **we** may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the **beneficiary**. This payment made in good faith satisfies **our** legal duty to the extent of that payment and **we** will not have to make payment again.

Also, at **our** option, **we** may pay up to $1,000 to the person or persons who, in **our** opinion, have incurred expenses for **your** last **sickness** or death.

SIMULTANEOUS DEATH

If a **beneficiary** dies on the same day **you** die, or within 120 hours of **your** time of death, the claim will be paid as if that **beneficiary** had died before **you**.

ASSIGNABILITY OF RIGHTS, TITLE AND INTEREST

The rights, title and interest provided to **you** by the policy are owned by **you**, unless:

1. **you** have previously assigned these rights, title and interest to someone else (known as an "assignee"); or
2. **you** assign **your** rights, title and interest under the policy(s) to an assignee.

We will recognize an assignee as the owner of the rights, title and interest under the policy if:

1. a **written** form satisfactory to **us** affirms the assignment;
2. the **written** form is **signed** by **you** and the assignee;
3. a **signed** or certified copy of the **written** assignment has been received and registered by **us** at **our** home office; and
4. the assignment is not prohibited by applicable **law.**

Unless otherwise noted by **you** in **your written** request for assignment, the assignment will take effect on the date the notice of assignment is **signed** by **you**, subject to any payments made or actions taken by **us** prior to receipt of the notice of assignment.

The right of any **beneficiary** to receive a benefit under the policy shall be subject and subordinate to the rights of any assignees.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the policy's provisions before receiving and registering an assignment. **We** will also not be responsible for the validity of any assignment.