CITIZENS SECURITY
Life Insurance Company
P.O. BOX 436149 • LOUISVILLE, KY 40253-6149

(called Citizens Security in this certificate)

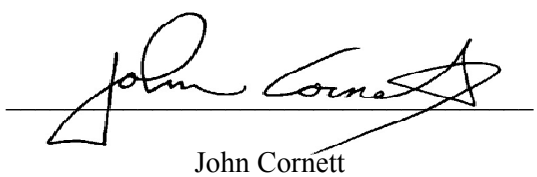
Citizens Security has issued a group policy to: CITY OF DUNN

(called the Policyholder in this certificate)

The group policy number is: 13324

The group policy is a contract between the Policyholder and Citizens Security. They are the only parties to the contract. The contract alone is the agreement by which payments are made. It may be changed or terminated only by one of these parties. This certificate, and the riders which may be attached to it, contains the main provisions of the group policy which affect the persons for whom it was prepared. If the group policy is changed in a way which will affect the insurance, a rider or a new certificate will be issued to describe the change.

When you meet the requirements for being insured, this document will be your certificate of insurance. The requirements are stated in this certificate. Read your certificate carefully.



John Cornett
PRESIDENT

GROUP INSURANCE CERTIFICATE

IMPORTANT CANCELLATION INFORMATION

Please read the provision entitled "Policy Term, Renewal and Termination," found on pages 12 and 13 of the Master Policy.

PRE-EXISTING CONDITIONS

Dental benefits are not payable for any services begun before the effective date of this certificate.

GR.116 NC

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SCHEDULE OF ELIGIBILITY

An eligible employee is an employee who is actively at work for the policyholder on the date of issue and who has met the eligibility requirements specified below; also anyone who is hired after that date and who has satisfied the eligibility requirements below.

ELIGIBILITY REQUIREMENTS (Waiting Period)

An employee becomes eligible to apply for coverage on the first of the month following 30 days of continuous active, full-time employment, working a minimum of 30 hours per week for the policyholder.

This policy includes Take Over / Continuation of Coverage. All employees / dependents covered on the last billing from the prior carrier will receive credit towards any waiting periods that is equivalent to the length of time they were insured with the prior carrier. Credit will also be given for an insured's deductible amount that was satisfied with the employer's previous dental carrier provided it is within the same calendar year. Benefit maximums will be limited to the maximums stated in the Schedule of Benefits less any amount paid by the prior carrier within the same calendar year.

SCHEDULE OF INSURANCE

DENTAL INSURANCE

TYPE A: Diagnostic and Preventive Care - 100% of Usual and Customary Charges. No deductible.
Available Only After 0 Months Continuous Coverage.

THE FOLLOWING SERVICES ARE SUBJECT TO A $ 50.00 ANNUAL DEDUCTIBLE, WITH A MAXIMUM OF 3 DEDUCTIBLES PER FAMILY.

TYPE B: Basic Care - 80% of Usual and Customary Charges.
Available Only After 0 Months Continuous Coverage.

TYPE C: Major Restorative - 50% of Usual and Customary Charges.
Available Only After 0 Months Continuous Coverage.

TYPE D: Orthodontic Services - 50% of Usual and Customary Charges.
Available Only After 0 Months Continuous Coverage.

**TYPE A, B & C Benefits Subject to an Annual Maximum of $ 1,000.00 Per Insured **

**Lifetime Orthodontic Services Subject to a Lifetime Maximum of $ 1,000.00 Per Insured Dependent **

***All Benefits Cease at Retirement ***

PRE-EXISTING CONDITIONS

Dental benefits are not payable for any services begun before the effective date of this certificate.

CLASSIFICATION OF DENTAL PROCEDURES

The following listing of dental procedures will explain the types of benefits described in the Schedule of Insurance.

TYPE A

This type includes procedures of a diagnostic or preventive nature. The procedures include:

- Clinical Oral Examinations – One such examination in any six consecutive month period.
- Bitewing x-rays – one set in any twelve consecutive month period – periapical x-rays as required.
- Dental Prophylaxis – Two procedures in a 12 month period. A five month interval must exist between prophylaxes.
- Fluoride Treatments - Limited to children dependents under the age of 16. One treatment per calendar year.
- Sealants – Limited to children dependents under the age of 14. Placement to the occlusal surface of permanent molars, once per lifetime.
- Space Maintainers – Limited to children dependents under the age of 14 – for the premature loss of a primary tooth.
- Full Mouth X-rays – including panoramic films – once in a five-year period.

TYPE B

This type includes basic restorative and corrective services. The procedures include:

- Amalgam and Resin Restorations – Limited to one filling per 24 months per tooth surface. Multiple restorations on a single surface will be paid as a single filling.
- Maintenance Prosthodontics – Adjustments and repairs to dentures and fixed bridges. Limited to adjustments and repairs performed more than 12 months after initial insertion.
- Emergency Care Treatment – Limited to the necessary procedures for the initial palliative treatment of pain and/or injury.
- Extractions – (Simple) Includes local anesthesia, suturing, if needed and routine follow-up care.
- Periodontics – Adjunctive Services – Includes diagnosis, scaling and root planing and periodontal prophylaxis (following active periodontal therapy). Limited to two prophylaxis procedures in a 12 month period, either periodontal or routine.
- Periodontics – Surgical Services.
- Endodontics – Includes pulpotomy, apicoectomy, retrograde fillings and root canal therapy.
- Oral Surgery – Includes pre-operative and post-operative care.
- Extractions – (Surgical) Includes impactions, residual roots and unerupted teeth.
- Anesthesia – General or IV sedation prompting a state of unconsciousness. Limited to eligible oral surgery procedures.

TYPE C

This type includes procedures for major restorative and corrective services. The procedures include:

- Gold Inlays and Onlays – Limited to teeth that cannot be restored by an amalgam or resin filling.
- Crowns – Benefits are provided only when the tooth, as the result of extensive decay or accidental injury, cannot be restored with a direct placement restoration.
- Prosthodontics – Complete or partial dentures, bridge pontics and abutment crowns. Bridge replacements limited to more than 10 years after the initial placement. Denture replacements limited to more than 5 years after prior placement.

TYPE D

Orthodontics includes comprehensive full-banded orthodontic treatment, and fixed or cemented appliances for tooth guidance or to control harmful habits.

BECOMING INSURED

All persons who are in the Eligible Group can be insured. You are in the Eligible Group if: (1) you are an employee of the Policyholder; and (2) you have a scheduled work week of thirty hours or more.

If you and your husband or wife are in the Eligible Group, either of you may choose to be covered: (1) as an employee; or (2) as a dependent.

If one chooses to be covered as a dependent, the other must choose to be covered as an employee.

You can be insured on your Eligibility Date. It is the Date of Issue if you are in the Eligible Group on that date.

For your insurance to begin, you must be actively at work. To be actively at work, you must: (1) be able to do the normal tasks of your job on a full-time basis for a full work day on the day your insurance is to begin; and (2) be able to do such tasks at one of your employer's normal places of business or at a location to which you must travel to do your job; and (3) not be absent from work because of leave of absence or temporary layoff. If you do not meet the requirements in the last sentence, insurance will begin on the next day on which you do meet these requirements.

If you are insured by the group policy, you can also be insured for your Eligible Dependents. Your Eligible Dependents are:

1. your husband or wife, if you are not legally separated or divorced; and

2. all your children who are not married, who:

    a. are less than 19 years of age and who live with you; or are less than 23 years old and
    b. are going to school full-time. Such child must be dependent on you for principal support and maintenance; or
    c. becomes incapable of self-support because of mental retardation or physical handicap while insured under the policy and prior to reaching the limiting age for dependent children. The children must be dependent on you for support and maintenance. We must receive proof of their incapacity, and then coverage will continue for as long as your insurance stays in force and the children remain incapacitated. Additional proof may be required from time to time but not more often than once a year; or
    d. you have been directed by court order to cover by insurance; or
    e. is a stepchild or legally adopted child or foster child. Once an adopted child is placed into the employee's home for the purpose of adoption, regardless of whether a final decree of adoption has been entered; provided that a petition for adoption has been duly filed and is pursued to a final decree of adoption; or once a foster child is placed in the employee's home. Placement in the foster home means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis. We will consider these children a dependent as long as (a), (b), (c) or (d) is met and any required premium is paid.

All of your dependents will become insured on the latest of the following: (1) the Date of Issue of the policy, (2) the date you become insured, provided all necessary forms have been completed, or (3) the first of the month following the date the dependent becomes eligible.

If the employee is not covered under a classification which includes dependent children, a newborn, foster or adoptive child is automatically insured to the same extent as the employee under the terms of the policy for injury or sickness on the date of birth of the newborn or date of placement in the foster or adoptive home, as long as the employee was insured on that date. A newborn, foster or adoptive child's coverage will not continue unless we are notified within the thirty-one (31) days of the child's birth or placement in the home and any required premium due is paid.

Your insurance ends on the earliest of (1) the date the group policy ends; (2) the date you are no longer in the Eligible Group, and (3) the date of retirement.

Your insurance may be continued if: (1) you are absent from work due to injury, sickness, leave of absence or temporary layoff; and (2) the Policyholder pays premiums for your insurance. Under these conditions your insurance can be continued for no more than three months.

Insurance for your dependents will end on the earliest of: (1) the date the group policy ends; (2) the date the group policy is changed to exclude insurance for your dependents; (3) the date your insurance ends; and (4) the date through which premiums were paid for your dependents if you stop your premium payments. Insurance for any one dependent will end on the date he or she ceases to be an Eligible Dependent.

COORDINATION OF BENEFITS

If this policy includes any other benefits provided by benefit inserts, the following provision does not apply to any unless specifically shown therein.

If any covered person has coverage for covered dental services under another plan, benefits payable under this plan will coordinate with benefits or services of that plan. Plan means any plan of: (1) group; (2) governmental program coverage (includes Medicare, Medicaid is excluded); (3) any prepayment coverage plans on a group basis; (4) any coverage through labor-management plans; and (5) any coverage required or provided by law. Benefits from any individual plans are not subject to Coordination of Benefits.

When the sum of the benefits that would be payable under this plan and other plans in the absence of Coordination of Benefits exceed the covered person's allowable charges, this plan will pay either its regular benefits in full or a reduced amount which, when added to the benefits available under other plans, will equal 100% of a covered person's allowable charges. (Allowable charges means the necessary, reasonable expenses covered under at least one of the plans.

Each benefit that would be payable in the absence of this provision will be reduced proportionately; and the reduced amount will be charged against any applicable benefit limit of this plan.

The rules for deciding which Plan pays first are:

1. If a person is the main insured under one plan and covered as a dependent under another plan, the plan under which the person is covered as the main insured will pay first.

2. If a person is covered as a dependent under two plans, the benefits of the plan which covers the insured for whom a claim is made as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of the plan which covers the insured as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. However, if the parents of a dependent child are separated or divorced, the following rules will apply:

    a. If the parent who has custody of the child has not remarried, that parent's plan will pay before the plan of the parent without custody of the child.

    b. If the parent who has custody of the child has remarried, that parent's plan will pay before the stepparent's plan. The stepparent's plan will pay before the plan of the parent without custody.

c. regardless of (a) and (b) above, if a court decree has ordered which parent must pay for the child's health care expense, that parent's plan will pay first.

3. When rules (1) and (2) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time; provided that:

   a. the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee or as the dependent of such person shall be determined after the benefits of any other plan covering such person as employee other than as a laid-off or retired employee or a dependent of such person; and

   b. if either plan does not have a provision regarding laid-off or retired employees, and as a result, each plan determines its benefits after the other, then the provisions of (a) above shall not apply.

CLAIMS

We should receive written notice of claim within 20 days after a covered person first has a loss covered by this policy. Written notice of claim may be sent to us at our home office or to any of our authorized agents. This written notice must include sufficient information to identify the person.

When we receive your notice of claim, the Policyholder or the covered person will be sent claim forms for filing of proof of loss.

The covered person must give us written proof of any loss at our home office within 15 months after the date of loss unless: (a) it was not reasonably possible to provide proof in that amount of time; or (b) he had no legal capacity. If a loss required more than one payment, he must give us proof within 15 months after the end of each covered period of time.

We will accept proof more than one year after the date it was required if the covered person could not provide it earlier because he had no legal capacity.

After we receive written proof of loss, we will pay monthly any benefits then due for a loss that continues for such a period.

Except as otherwise provided, all benefits under this policy will be paid to the covered person. It the person is a minor or otherwise not competent to give a valid release, payments will be made to his parent, guardian or any other person who is actually supporting him. We may, in our discretion, pay those benefits to the provider rendering the service. A payment that we make in good faith under this provision will release us from any further liability to the extent of such payment.

You may not bring legal action to recover on the policy: (a) earlier than 60 days after we receive written proof of loss; or (b) later than three years following the date on which we required written proof of loss.

BENEFITS

"Deductible" means the dollar amount of Covered Expenses that must be incurred before benefits can be paid. The amount of the Deductible is shown in the Schedule of Insurance. It applies once in each calendar year to each person insured, except as explained below regarding "Family Deductible." Calendar year means the period from January 1 through December 31, so a calendar year deductible is reapplied January 1, regardless of when the insured's coverage started in the prior year.

LIMITATIONS

Pretreatment review by the Company is required when treatment plan exceeds $300.00 or involves inlays, crowns, onlays, veneers, dentures, bridges, oral surgery, or periodontics. We will pay only for a less expensive procedure than the one proposed if Citizens Security determines that the procedure is adequate.

Benefits for supplementary bitewing x-rays will not be provided more often than once in a calendar year. Benefits for prophylaxis will be limited to two per 12 month period. Topical fluoride will not be covered for people over age 16. Sealants are limited to the occlusal surface of permanent molars with no prior restorations on dependents under age 14. Replacement of crowns and dentures will not be covered if they are made less than five years after the appliance was provided under this contract. Replacement of bridges will not be covered if they are made less than 10 years after prior placement. Benefits will not be provided for the surgical removal of implants. If allowance is made toward the cost of implants, there will be no payment for replacement appliances for five years.

Benefits will be limited to 30% of the Annual Maximum stated in the Schedule of Benefits, per insured, for expenses incurred during the first twelve months of coverage for any insured person whose effective date is more than thirty-one days from the date the insured person qualified for insurance.

EXCLUSIONS

No payment will be made for, and charges incurred by a covered person will not be applied toward satisfaction of a deductible if they are for:

1. dental care or treatment for a dental condition which arises out of the covered person's occupation (applicable only if the law requires that Workman's Compensation coverage be made available to the group); or
2. services started prior to the effective date of coverage under this contract; or
3. services required for teeth extracted prior to the effective date of coverage; or
4. services by a dentist who resides in the home of the member; or
5. appliances or restorations necessary to increase vertical dimensions or restore occlusion other than those defined and limited in the contract; or
6. dental services primarily for cosmetic or esthetic purposes; or
7. treatment of fractured jaw bones (maxilla, mandible, malar and/or zygomatic arch); or
8. orthodontic services including x-rays taken as part thereof unless otherwise stated in the Schedule of Insurance; or
9. splinting procedures (periodontal splinting and "double abutments"); or
10. services to replace tooth structure lost as the result of attrition, abrasion, erosion, or abfraction (tooth wear); or
11. denture or bridge replacements made necessary because of the loss or theft of the denture or bridge or duplicates of serviceable dentures; or
12. gold foil restorations; or
13. dental services for which the covered person incurred no charge; or
14. expenses incurred for any procedures begun after the individual's insurance terminates; or for any prosthetic dental appliances finally installed or delivered more than 90 days after the individual's insurance terminates;
15. expenses incurred for failure to keep a scheduled visit.

ORTHODONTIC BENEFIT

When an eligible person incurs expenses for covered orthodontic expenses we will pay benefits at the benefit percentage shown in the Schedule of Insurance. The amount paid is also subject to the exclusions and limitations of this policy and to the annual and lifetime maximum amount shown in the Schedule of Insurance.

Unless specifically stated in the Schedule of Insurance, "eligible person" means only a covered dependent child under 19 years of age.

Orthodontic expenses are the reasonable and customary charges made by a dentist for orthodontic diagnosis or evaluation, pre-orthodontic treatment and the furnishing and installation of orthodontic appliances. Predetermination of benefits is required in each instance.

Payment will be made only as follows:

(A) an initial payment when appliances are placed or banding completed, not to exceed 1/3 of the total charges for the entire course of orthodontic treatment.

(B) a monthly amount equal to the difference between the initial amount and the total benefits for the entire course of orthodontic treatment divided by the number of months in the projected period of treatment shown in the predetermination of benefits.

Monthly benefits will cease on the payment due date next following:

(A) the end of the specified period of treatment; or

(B) termination of treatment for any cause prior to completion of the course of treatment; or

(C) the date the person ceases to be eligible; or

(D) the date the policy terminates; or

(E) the date the person becomes age 19; or

(F) the end of the last period for which the required premium for the person has been paid.

EXCEPTIONS

Expenses for orthodontia started before the person has been covered under the policy are not covered expenses.

Expenses for replacement and/or repair of an orthodontic appliance furnished in whole or in part under this policy are not covered expenses.

Orthodontic expenses are covered only if the bands or appliances are initially placed while the person is covered under this policy.

CERTIFICATE AMENDMENT

POLICYHOLDER:	City of Dunn
ISSUE DATE:	July 1, 2008
GROUP POLICY NUMBER:	13324
AMENDED PAGE:	4B – GR.116

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The above referenced policy contract is hereby amended by Citizens Security Life Insurance Company to change the Schedule of Insurance.

TYPE D – ORTHODONTIC SERVICES is no longer subject to the $50 Annual Deductible.

This amendment is effective July 1, 2008. All other provisions will remain in effect as stated in the policy.

Signed on the 24th day of June, 2008 on behalf of Citizens Security Life Insurance Company

Nedra D. Mills, Vice President
Claims and Group Administration

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

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

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

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0128

North Carolina Department of Insurance, Consumer Division
Post Office Box 26387
Raleigh, North Carolina 27611

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they life in North Carolina and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws for another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under — 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

CITIZENS SECURITY LIFE INSURANCE COMPANY
P.O. BOX 436149
LOUISVILLE, KENTUCKY 40253-6149

NORTH CAROLINA GROUP NOTIFICATION

Under North Carolina General Statute Section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of Chapter 58 of the general statutes and their rights to purchase individual policies under the Federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the General Statutes. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

Citizens Security Life Insurance Company, Louisville, Kentucky, provides this notice as required by North Carolina Senate Bill 241.

CITIZENS SECURITY LIFE INSURANCE COMPANY

P.O. BOX 436149 • LOUISVILLE, KENTUCKY 40253-6149

PRIVACY NOTICE

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Citizens Security Life Insurance Company (the "Company") is required by law to provide individuals with notice of its legal duties and privacy practices with respect to its use and disclosure of personally identifiable health information ("protected health information") in its possession, and is required to abide by the terms of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Company is permitted to use and disclose protected health information to underwrite health risks and to administer and pay claims on health risks it insures.

Otherwise, the Company will not use or disclose protected health information except:

- To the individual to which the protected health information pertains upon the written request of that individual.
- Pursuant to and in compliance with a valid authorization signed by the individual to which the protected health information pertains; provided that the individual may revoke such authorization in writing.
- To the Company's affiliate, Citizens Financial Corporation, pursuant to an agreement requiring Citizens Financial Corporation to abide by the terms of this Notice.
- To create and disclose health information that is not identifiable with any individual.
- When required by the Secretary of Health and Human Services.
- When required in judicial or administrative proceedings or for law enforcement purposes.
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

RIGHTS OF INDIVIDUALS

An individual has the following rights with respect to protected health information pertaining to that individual:

- To request the Company to place additional restrictions on the use and disclosure of protected health information; provided that the Company is not legally required to agree to such additional restrictions.
- To require the Company to send confidential communications of protected health information to him or her by alternative means or at an alternative location if the individual states that the disclosure of all or part of the protected health information could endanger the individual.
- To require the Company to permit the individual to inspect and copy protected health information.
- To require the Company to mend inaccurate or incomplete protected health information created by the Company.
- To require the Company to account to the individual for disclosures of protected health information; provided, the Company is not required to account for disclosures required for treatment, payment or health care operation, or which are permitted by this Notice.
- To require the Company to provide a paper copy of this Notice to the individual.

The above rights may be exercised by the individual delivering a written notice to the Company specifying the right or rights which the individual is exercising.

COMPLAINTS

Individuals may file a written complaint with the Company and the Secretary of Health and Human Services if they believe their privacy rights have been violated. Individuals will not be retaliated against for filing a complaint.

RIGHTS OF INDIVIDUALS

The Company reserves the right to amend this Notice provided the amended Notice complies with all applicable laws and is delivered to the individuals to which the amended Notice applies.

Individuals requiring further information concerning the Company's privacy policies and this Notice should contact:

ATTN: Policyowners Service Department
Citizens Security Life Insurance Company
12910 Shelbyville Road, Suite 300
Louisville, Kentucky 40243

Phone: 800.843.7752
502.244.2420
Fax: 502.244.2439
Website: www.citizenssecuritylife.com

EFFECTIVE DATE

This Notice is effective April 14, 2003.