

Term Life Insurance

Employee Benefit Booklet



SOUTHWESTERN COMMUNITY COLLEGE

F013385-0001

Class 1-03

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.
01/12/2010

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

Having issued Group Policy No. F013385-0001

(herein called the Policy)

to

SOUTHWESTERN COMMUNITY COLLEGE

(herein called the *Policyholder*)

GROUP INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.


This Certificate describes *Your* eligibility for benefits and the terms and provisions of the Policy. It replaces and cancels any other Certificate previously issued to *You* under the Policy.

If the terms and provisions of the Group Insurance Certificate (issued to *You*) are different from the policy (issued to the *Policyholder*), the Policy will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

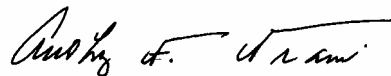
**THIS CERTIFICATE IS RENEWABLE AT THE OPTION OF FORT DEARBORN LIFE
INSURANCE COMPANY**

READ YOUR CERTIFICATE CAREFULLY

Signed for Fort Dearborn Life Insurance Company



Secretary



President

Basic Group Term Life Insurance Certificate

Non-Participating

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SCHEDULE OF BENEFITS

POLICYHOLDER: SOUTHWESTERN COMMUNITY COLLEGE
POLICY NUMBER: F013385-0001
EFFECTIVE DATE: January 1, 2010

ELIGIBILITY: All eligible Retirees age 65 and above of the Policyholder. An eligible Retiree is one:
Class 03 Who was continuously employed by the *Policyholder* as a full-time *Employee* for five years prior to retirement (or for the entire existence of the *Policyholder* if the firm has been in existence more than one but less than five years); and

1. whose age plus total length of service with the *Policyholder* equals or exceeds 60; and
2. who is not eligible for life insurance benefits as an active *Employee* of any other organization; and
3. who remains continuously covered under the *Policyholder's* group life insurance plan from the date of his retirement.

Eligibility Waiting Period: Current *Retirees*: None
New *Retirees*: None

Policyholder Contribution: Basic Life 100% of premium

GROUP TERM LIFE INSURANCE

Employee Basic Life Benefit Amount \$10,000
Reduction of Benefits None.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is set forth in the Schedule of Benefits.

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Are Retirees Eligible?

Yes, but only if the *Policyholder*:

1. has defined retirees as an eligible class on his *Application*; and
2. has agreed to pay at least 100% of the premium for retiree coverage.

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When does Your Noncontributory insurance become effective?

Noncontributory means the *Policyholder* pays 100% of the premium for this insurance.

Current Retirees

If *You* are an eligible *Retiree* on the Policy effective date, *Your Noncontributory* coverage under the Policy will become effective on the date indicated in the Schedule of Benefits.

New Retirees

If *You* become an eligible *Retiree* after the Policy effective date, *Your Noncontributory* coverage under the Policy will become effective on the date indicated in the Schedule of Benefits.

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

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Evidence of Insurability means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. *Evidence of Insurability* will be provided at *Your* expense.

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Changes to Your coverage

A change in *Your* coverage may occur if:

1. There is a Policy change; or
2. *You* enter another class and become eligible for a change in benefits; or

If *You* are eligible for additional coverage due to a Policy change, the additional coverage will be effective on the date the Policy change is effective, as requested by the *Policyholder* and agreed upon by *Us*.

Additional coverage for reasons other than a Policy change will be effective as indicated in the "***When Does Your Non-Contributory insurance become effective?***" section, or the later of:

1. The date *You* enroll for the additional coverage; or

2. The date *You* become eligible for the additional coverage, if enrollment is not required; or
3. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

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TERM LIFE INSURANCE BENEFIT

When is a Life Insurance Benefit payable?

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

1. *You* are insured under the Policy on the date of death, and
2. *We* receive proof of death within two (2) years after the date of death.

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

00012

Who will receive Your Life Insurance Benefits?

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

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

Facility of Payment

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

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

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than \$250 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death. Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.

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May You change Your beneficiary?

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

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CONVERSION OF LIFE INSURANCE

How much Life Insurance may You convert if eligibility terminates?

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

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

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

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

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

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

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

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

How to apply for conversion

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

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

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

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

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

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

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

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

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

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

1. the date on which the Policy is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the effective date of an amendment to the Policy which terminates insurance for the class to which *You* belong; or
4. the date *You*:
 - a. are no longer a member of a class eligible for this insurance,
 - b. request termination of coverage under the Policy,

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GENERAL PROVISIONS

Entire Contract; Changes

The Policy, the Policyholder's Application, the Retiree's Certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the *Policyholder* and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the Policyholder in applying for the Policy will make it void unless the representation is contained in his signed Application; or
2. any Retiree in applying for insurance under the Policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the Retiree, is or has been given to the Retiree.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against *Us*:

1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof of *Loss* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

Clerical error or omission by *Us* to the Policyholder will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the Policyholder gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Incontestability

The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the Policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the Policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates.

Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is

for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If *You* have misstated *Your* age, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

Conformity with State Statutes and Regulations

If any provision of the Policy conflicts with the statutes and regulations of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

Assignment

You may assign any incident of ownership *You* may possess of the life insurance benefits provided under the Policy to anyone other than the *Policyholder*. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

Retention of Discretion

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn and such decisions shall be final and conclusive.

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DEFINITIONS

This section tells *You* the meaning of special words and phrases used in this Certificate. To help *You* recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Activities of Daily Living means:

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

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

00066

Dependent or Eligible Dependent means:

1. *Your* lawful *Spouse or Domestic Partner*; and/or
2. *Your* unmarried child who is within the age limits set forth in the Schedule of Benefits, and who is not in active military service.

Eligible Dependents Include

1. *Your* natural or step child.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your* dependent for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

00072

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

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Insured means an Retiree covered under the Policy.

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Male Pronoun whenever used includes the female.

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Non-Contributory means the *Policyholder* pays 100% of the premium for this insurance.

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

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Policyholder means the person, firm, or institution to whom the Policy was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the Policy. If the *Policyholder* is an association, the term *Participating Employer* shall be substituted for *Policyholder*.

00098 NC

Proof under the Accelerated Death Benefit means evidence satisfactory to Us that *You* have a *Terminal Condition*. We reserve the right to determine, at our sole discretion, if Proof is acceptable.

00100

Registered Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You*, similar to that of a *Spouse*, as evidenced by the following:

1. *You* and *Your Domestic Partner* share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. *You* and *Your Domestic Partner* each are at least eighteen (18) years of age;
3. *You* and *Your Domestic Partner* are both mentally competent to enter into a binding contract;
4. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and

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

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

00104

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

00105

Sickness means illness, disease, pregnancy or complications of pregnancy. Complications of pregnancy affect that part of *Your* pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy during the delivery or after delivery.

00109 NC

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

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

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**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, NC 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. Following 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 live in this state and hold a life or health insurance contract, or an annuity, 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 of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The 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 the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy for a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter the number policies or types of policies issued by the insolvent company.

ERISA INFORMATION STATEMENT*

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

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

A. ADMINISTRATION OF THE PLAN

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

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

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

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. FDL's (the Insurer's) services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

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

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a). The Employer makes no promise to continue these * If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE:

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

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

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

1. Disability Insurance Plans

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

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

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

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

You may:

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

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

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

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

2. Life Insurance Plans

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

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed; and
- the steps that have to be followed to have the claim reviewed.

Any denied claim may be appealed to the Insurer for a full and fair review. The claimant may:

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

A decision will be made by the Insurer no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision will advise you of any other appeal rights you have under the Plan, as well as your right to bring an action under Section 502(a) of ERISA.

C. ERISA NOTICE OF YOUR RIGHTS

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

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

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

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the

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denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

D. PARTICIPANT'S RIGHTS

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

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Administrative Office:
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