



Term Life and AD&D Insurance

Employee Benefit Booklet

TOWN OF ELIZABETHTOWN

F014267-0001

Class 1-04

Dearborn Life Insurance Company

Administrative Office:
701 E. 22nd Street
Lombard IL 60148

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

Having issued Group Policy No. F014267-0001

(herein called the *Policy*)

to

TOWN OF ELIZABETHTOWN

(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*.

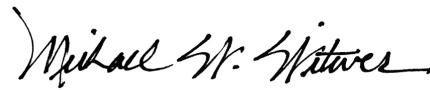
**THIS CERTIFICATE IS RENEWABLE AT THE OPTION OF
DEARBORN LIFE INSURANCE COMPANY**

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company



Secretary



President

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

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SCHEDULE OF BENEFITS

POLICYHOLDER: TOWN OF ELIZABETHTOWN
POLICY NUMBER: F014267-0001
EFFECTIVE DATE: July 1, 2015 - Revised: September 1, 2024

ELIGIBILITY: Class 04 ALL ACTIVE FULL-TIME ELECTED OFFICIALS of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.

Eligibility Waiting Period: Current *Employees*: First of the month following 30 Days of continuous, full-time active work
New *Employees*: First of the month following 30 Days of continuous, full-time active work

Policyholder Contribution: Basic Life & AD&D 100% of premium

GROUP TERM LIFE INSURANCE

Employee Basic Life Benefit Amount \$10,000

Reduction of Benefits Basic Group Term Life benefits reduce by 35% of the original amount at age 70 and further reduce to 50% of the original amount at age 75. Benefits terminate at retirement.

Waiver of Premium

Waiver Eligibility Totally Disabled prior to age 60 without interruption from the last date worked for at least 6 months
Insured Eligibility *Employee*
Maximum Waiver of Premium Duration Age 65

Accelerated Death Benefit (ADB)

Benefit Amount 75% Basic Term Life Insurance In force
Insured Eligibility *Employee*
Minimum Covered Life Insurance Amount \$15,000
Maximum ADB Payment \$250,000
Minimum ADB Payment \$7,500

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

Employee Basic AD&D Coverage Amount \$10,000

Reduction of Benefits Basic Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 70 and further reduce to 50% of the original amount at age 75. Benefits terminate at retirement.

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

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

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

Education Benefit

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

Maximum Benefit Duration Benefit payable for a maximum of 4 Years

Eligible Dependents Age live birth to age 19 years (23 if a full-time student)

Felonious Assault Benefit

Employee Coverage Amount to a maximum of \$25,000

In the Line of Duty Benefit

50% of *Employee Coverage Amount* to a maximum of \$50

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

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

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

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When does Your Noncontributory insurance become effective?

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

Current Employees

If *You* are an eligible *Employee* on the *Policy* effective date, *Your Noncontributory* coverage under the *Policy* will become effective on the date indicated in the *Schedule of Benefits*, provided *You* are *Actively at Work* on that day.

New Employees

If *You* become an eligible *Employee* after the *Policy* effective date, *Your Noncontributory* coverage under the *Policy* will become effective on the date indicated in the *Schedule of Benefits*, provided *You* are *Actively at Work* on that day.

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.

You must be *Actively at Work* for coverage under the *Policy* to become effective.

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When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date or *You* were eligible to enroll under the *Prior Policy* and did not enroll before the expiration of the time allowed to enroll; or
2. *You* voluntarily canceled *Your* insurance and choose to reapply; or
3. *Your* coverage amount exceeds the Guarantee Issue Benefit Limit as set forth in the *Schedule of Benefits*; or

Receipt of premium before *We* have approved *Evidence of Insurability* will not constitute acceptance and does not guarantee issuance of any benefit amount prior to *Our* approval.

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

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

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an *Injury*, illness or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work*.

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

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

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What happens if We are replacing an existing Policy? Is continuity of coverage provided?

If *You* were insured for coverage under the *Prior Policy* on the day immediately preceding *Our Policy*'s Effective Date, and subject to the payment of premiums when due, *We* agree to provide continuity of coverage for *You* if *You* are not

Actively at Work on *Our Policy* Effective Date. If *Your* coverage is extended under this provision, *You* are not eligible for *Waiver of Premium* benefits under *Our Policy*.

Coverage under this provision will end on the earlier of:

1. The date *You* return to *Active Work*, at which time *You* may be covered as an *Actively at Work Insured* under *Our Policy*;
2. The last day of the 12th month following *Our Policy* Effective Date;
3. The last day *You* would have been covered under the *Prior Policy* had the *Prior Policy* not terminated;
4. The date *You* are approved for *Waiver of Premium* under the *Prior Policy*; or
5. The date insurance terminates for one of the reasons stated in the Termination Provisions of *Our Policy*.

The amount of coverage provided will be the lesser of:

1. The amount of coverage *You* had under the *Prior Policy*; or
2. The amount of coverage *You* are eligible for under *Our Policy*.

Reduced by any amount:

1. In-force, paid or payable under the *Prior Policy*; or
2. Which would have been payable if timely election had been made under the *Prior Policy*.

Prior Policy means the group term life insurance policy issued to the *Policyholder* whose coverage terminated immediately prior to *Our Policy* Effective Date.

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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.

In order for *Your* additional coverage to begin, *You* must be *Actively at Work*.

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Eligibility after You Terminate Employment

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

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

1. apply a new *Eligibility Waiting Period*

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

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TERM LIFE INSURANCE BENEFIT

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*.

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Who will receive Your Life Insurance Benefits?

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

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

Facility of Payment

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

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

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than \$250 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death.

Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.

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May You change Your beneficiary?

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

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

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

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CONVERSION OF LIFE INSURANCE

How much Life Insurance may You convert if eligibility terminates?

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

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

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

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

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

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

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

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

How to apply for conversion

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

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

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

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

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

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

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

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WAIVER OF PREMIUM

What is the Waiver of Premium benefit?

We will continue *Your* Basic life insurance benefit under the *Policy* without further payment of life insurance premium if *You* become *Totally Disabled*, provided:

1. *You* are insured under the *Policy* and were *Actively at Work* on or after the effective date of the *Policy*; and
2. *You* are under the age of 60; and
3. *You* provide *Us* with satisfactory written proof of *Total Disability* within 12 months after the date *You* became *Totally Disabled*; and
4. *Your Total Disability* has continued without interruption for at least 6 months; and
5. *You* are still *Totally Disabled* when *You* submit the proof of disability; and
6. all required premium has been paid.

Total Disability or **Totally Disabled** means *You* are diagnosed by a *Doctor* to be completely unable because of *Sickness* or *Injury* to engage in any occupation for wage or profit or any occupation for which *You* become qualified by education, training or experience.

We will waive premium beginning the month after We receive satisfactory proof that *You* have been **Totally Disabled** for at least 6 months. Premium will continue to be waived provided *You*:

1. remain **Totally Disabled**; and
2. provide satisfactory written proof of continuing **Total Disability** upon request.

You are responsible for obtaining initial and continuing proof of **Total Disability**.

You will be covered for the amount of life insurance in force as of the date **Total Disability** commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as shown on the *Schedule of Benefits* or which are the result of an amendment to the *Policy*, but in no event will the insurance amount increase while *Your* life insurance is continued under Waiver of Premium. This life insurance coverage will continue without the payment of premium until *You* are no longer **Totally Disabled**, or attain the Maximum Waiver of Premium Duration as set forth in the *Schedule of Benefits* or retire, whichever occurs first.

We may have *You* examined at reasonable intervals during the period of claimed **Total Disability**. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if *You* refuse to be examined as and when required.

If *You* are approved for continued coverage under the Waiver of Premium provision, *You* will be asked to name a beneficiary. That beneficiary designation:

1. will only apply while *Your* coverage continues under this Waiver of Premium provision; and
2. if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*.

We will pay the amount of life insurance in force to *Your* beneficiary if *You* die before furnishing satisfactory proof of **Total Disability**, if:

1. *You* die within one year from the date *You* became **Totally Disabled**; and
2. We receive proof that *You* were continuously **Totally Disabled** until the date of death; and
3. We receive proof of death not more than two (2) years after *Your* death.

If continuation of life insurance under the Waiver of Premium provision ceases while the *Policy* is still in force, and *You* are employed by the *Policyholder*, *Your* life insurance will continue provided premium payments begin on the next premium due date. If *You* return to work with the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, We will pay death benefits in accordance with the Facility of Payment provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are no longer employed by the *Policyholder*, *You* may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of this Certificate.

How does termination of the Policy affect Your insurance under the Waiver of Premium Benefit?

Termination of the *Policy* will not affect any insurance that has been continued under this Provision prior to the termination date.

What if You are Totally Disabled and the Policy ends before You satisfy the Elimination Period?

Your coverage under the *Policy* will end if the *Policy* ends before *You* satisfy the *Elimination Period*. However, when the *Policy* ends *You* may be entitled to convert *Your* coverage to an individual plan of life insurance as described in the Conversion of Life Insurance provision.

You may still submit a claim for Waiver of Premium Benefits after the *Policy* ends. However, *You* must be **Totally Disabled**, pay the Conversion premium for the full length of the *Elimination Period* and qualify for the Waiver of Premium Benefits.

At no time can You be covered under both the individual conversion policy and this Policy.

Upon receipt of timely notice and due proof of *Your Total Disability* We will evaluate *Your* claim. If We determine that *You* qualify and *You* pay all applicable premiums, We will approve *Your* Waiver of Premium claim under the *Policy* and agree to rescind any individual policy of life insurance issued to *You* under the Conversion privilege. We will refund

any premiums paid for such coverage. Insurance under the *Policy* will not go into effect until We approve your claim in writing.
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ACCELERATED DEATH BENEFIT

The benefit paid under this provision may be taxable. If so, You or Your beneficiary may incur a tax obligation. As with all tax matters, You or Your beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect Your eligibility for Medicaid or other governmental benefits or entitlements.

What is the Accelerated Death Benefit?

The *Accelerated Death Benefit* is a percentage of Your group Basic term life insurance which is payable to You prior to Your death if We receive *Proof* that You have a *Terminal Condition*. The *Accelerated Death Benefit* is limited to the maximum and minimum amounts shown on the *Schedule of Benefits*, and is payable only once to any one *Insured*.

The *Accelerated Death Benefit* is calculated on the group Basic term life insurance benefit amount in force under the *Policy* on the date You are diagnosed with a *Terminal Condition*. If Your group term life insurance will reduce, due to age, within 12 months after the date We receive *Proof*, the *Accelerated Death Benefit* will be calculated on the reduced group Basic term life insurance benefit.

Who is Eligible for an Accelerated Death Benefit?

This benefit only applies to *Insureds* with at least the Minimum Covered Life Insurance Benefit amounts set forth in the *Schedule of Benefits*. You must have been *Actively at Work* on or after the effective date of the *Policy* to be eligible for an *Accelerated Death Benefit*.

This benefit does not apply to Accidental Death and Dismemberment benefits.

Terminal Condition means You have been examined and diagnosed by Your *Doctor* as having a medically determined condition which is expected to result in death within 12 months from the date that a claim for benefit under this provision is received by Us. We have the sole right to determine if such *Proof* is acceptable.

The Accelerated Death Benefit Payment

We will pay the benefit during Your lifetime if You are diagnosed with a *Terminal Condition* if You or Your legal representative submits a claim for an *Accelerated Death Benefit* and provides satisfactory *Proof*. The benefit will be paid in one sum to You.

Are there any exceptions to the payment of the Accelerated Death Benefit?

The *Accelerated Death Benefit* will not be payable:

1. for any amount of group term life insurance which is less than the Minimum ADB Payment as set forth in the *Schedule of Benefits*; or
2. if Your *Terminal Condition* is the result of:
 - a. attempted suicide, while sane or insane; or
 - b. intentionally self-inflicted injury; or
3. if Your group term life insurance benefit has been assigned; or
4. if Your group term life insurance benefit is payable to an irrevocable beneficiary, including notification to Us that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement; or
5. to retirees.

Notice and Proof of Claim

You must elect the *Accelerated Death Benefit* in writing on a form that is acceptable to Us. You must furnish *Proof* that You have a *Terminal Condition*, including certification by a *Doctor*.

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.

Effect on Insurance

The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon Your death. When the *Accelerated Death Benefit* is paid:

1. the term life insurance benefit otherwise payable upon *Your* death will be reduced by the amount of the *Accelerated Death Benefit*;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

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What happens to my coverage if I recover from the Terminal Condition?

If *Your Doctor* certifies that *You* no longer have a *Terminal Condition* and:

1. *You* return to work in an eligible class, coverage will remain in force, provided premium is paid when due.
2. *You* do not return to an eligible class but *You* are approved for continued life insurance coverage under the Waiver of Premium provision, coverage will remain in force, subject to the terms and conditions of the Waiver of Premium provision.
3. *You* do not return to an eligible class, and *You* do not qualify for continued life insurance, coverage will end and *You* may apply for conversion to an individual policy of life insurance in accordance with the applicable terms, conditions and time limits set forth in the Conversion of Life Insurance provision of the *Policy*.

In any event, the amount of coverage eligible to be continued or converted will be reduced by the amount of the *Accelerated Death Benefit* paid.

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ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

What is the AD&D Benefit?

If, while insured under the *Policy*, *You* suffer an *Injury* in an *Accident*, *We* will pay for those *Losses* set forth in the "Table of Losses" below. The amount paid will be the percentage stated in the Table of Losses but not more than the Coverage Amount set forth in the *Schedule of Benefits*. The *Loss* must:

1. occur within 365 days of the *Accident*; and
2. be the direct and sole result of the *Accident*; and
3. be independent of all other causes.

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

Definitions which apply to the AD&D Provision:

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.

Hemiplegia means total *Paralysis* of one arm and one leg on the same side of the body.

Loss, with respect to hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

Paralysis means loss of use without severance of a limb as a result of an *Injury* to the Spinal Cord, which has continued for 12 months. *Paralysis* must be determined by a *Doctor* to be permanent, total and irreversible.

Paraplegia means total *Paralysis* of both legs.

Quadriplegia means total *Paralysis* of both arms and both legs.

Uniplegia means total *Paralysis* of one limb.

The total amount of AD&D benefits payable for all *Losses* for any *Insured* resulting from any one *Accident* will not be greater than the Coverage Amount set forth in the *Schedule of Benefits*.

Except as provided in a particular AD&D benefit provision, We will pay benefits for loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other *Losses* will be paid to *You*.

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SEAT BELT BENEFIT

What is the Seat Belt Benefit?

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

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

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

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

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

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AIR BAG BENEFIT

What is the Air Bag Benefit?

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

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

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

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

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REPATRIATION BENEFIT

What is the Repatriation Benefit?

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

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

00033

EDUCATION BENEFIT

What is the Education Benefit?

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

Definitions which apply to the Education Benefit:

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

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

School of Higher Education means an institution which:

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

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

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

Special Child Education Benefit: If *Your Eligible Dependent* child does not qualify as a *Student*, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of \$1,000. This benefit is payable once upon proof that *You* died as a result of an Accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after *Your* death, *Your Eligible Dependent Child* is a full-time student in an elementary or high school.

00034

FELONIOUS ASSAULT BENEFIT

What is the Felonious Assault Benefit?

We will pay an additional amount, as set forth in the *Schedule of Benefits* in the event of *Your* death, to *Your* designated beneficiary if:

1. Loss of life occurs while *You* are on the business of the *Policyholder* or commuting to or from the premises of the *Policyholder*; and
2. Loss of life is the direct result of any of the following:
 - a. Robbery, holdup or attempt thereat;
 - b. Kidnapping while attempting a holdup;
 - c. Felonious assault inflicted by persons other than fellow *Employees* or members of *Your* family or household.

00039

IN THE LINE OF DUTY BENEFIT

We will pay an additional amount, as stated in the *Schedule of Benefits* in the event of *Your* death to *Your* designated beneficiary if *You* incur a *Loss of Life* as the direct result of an *Injury* sustained in a covered *Accident* while employed as a *Public Safety Officer* and on Duty for the *Policyholder*.

A ***Public Safety Officer*** means a person whose primary job duties include controlling or reducing crime, criminal law enforcement and fire suppression.

00042

EXPOSURE AND DISAPPEARANCE

If, as a result of an *Accident* while insured for this benefit, if *You* are unavoidably exposed to the elements and suffer a *Loss* as a result of that exposure, that *Loss* will be covered. If *Your* body has not been found within one (1) year of an *Accidental* disappearance, forced landing, sinking or wrecking of a conveyance in which *You* were occupants, *You* will be deemed to have suffered loss of life.

00043

LIMITATIONS

Are there any Limitations for losses due to an Accident?

We will not pay any benefit for any *Loss* that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. bacterial infection, except bacterial infection of an *Accidental* cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. war, declared or undeclared, whether or not *You* are a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance taken or inhaled voluntarily, unless as prescribed by a licensed physician and used in the manner prescribed. Controlled substance shall have the meaning as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

00050 NC

UNIFORM PROVISIONS

(Applicable to Dismemberment Coverage Only)

Initial Notice of Claim

We must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, We will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof of Loss* if We receive written *Proof*, which describes the occurrence, extent and nature of the *Loss*.

Proof of Loss

We must receive written *Proof of Loss* within 180 days after the date a *Loss* is incurred. If it is not possible to give Us written *Proof* within 180 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof of Loss* must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid for late claims if it can be shown that:

1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof of Loss* satisfactory to Us was given as soon as was reasonably possible.

For the Education Benefit, *Proof of Loss* must:

1. Include *Proof of Dependent Student* status; and
2. Be submitted no later than
 - a. Two months after completion of course work for that particular school year if the *Dependent Student* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall be deemed to begin on September 1st and end on August 31st; or
 - b. Within six (6) months after enrollment in a *School of Higher Education* if the *Dependent Student* is in the 12th grade at the time of *Your* death.

After the first year in a *School of Higher Education*, due *Proof* must be submitted in accordance with the time limits defined in Item (a) above.

Physical Examination/Autopsy

Upon receipt of a claim, We may examine an *Insured*, at *Our* expense, at any reasonable time. We reserve the right to perform an autopsy, at *Our* expense, if it is not prohibited by any applicable local law(s).

00051 NC

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

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

1. the date on which the *Policy* is terminated;
 2. the date You stop making any required contribution toward payment of premiums;
 3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which You belong; or
 4. the date You:
 - a. are no longer a member of a class eligible for this insurance,
 - b. request termination of coverage under the *Policy*,
 - c. are retired or pensioned, or
 - d. are no longer *Actively at Work* as a result of a disability, layoff, leave of absence, sabbatical, or military leave.
- However, You may continue to be eligible for group insurance coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due, the <i>Policy</i> is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due, the <i>Policy</i> is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.
Leave of Absence	Until the end of the month following the month during which the leave began, or, the period of time in accordance with the FMLA provision below, provided all premiums are paid when due, the <i>Policy</i> is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.
Sabbatical	Until the end of the month following the sixth month in which the sabbatical began, provided all premiums are paid when due, the <i>Policy</i> is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, provided all premiums are paid when due, the <i>Policy</i> is in force, and Your coverage is not replaced with group life insurance provided by a new carrier.

For the purposes of this Termination Provision only, *Disability* means You are unable to perform all of the *Material* and *Substantial Duties* of Your *Regular Occupation*.

00052a

Will coverage be continued if You are eligible for leave under FMLA?

In the event You are eligible for and the *Policyholder* approves a leave under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, the *Policy* is in force and Your coverage is not replaced with group life insurance provided by a new carrier, Your insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in Your home; or
4. To a *Spouse*, child or parent due to their serious illness; or
5. For Your own serious health condition.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the required premium according to the terms of the *Policy*; and
2. coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the *Policyholder*.

00053a

GENERAL PROVISIONS

Entire Contract; Changes

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

Statements on the Application

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

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

Legal Actions

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

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

Clerical Error

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

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

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

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

Incontestability

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

Premium Provisions

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

Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

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

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

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

Conformity with State Statutes and Regulations

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

Assignment

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

Retention of Discretion

We 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 *Our* sole discretion and such decisions shall be final and conclusive.

00055 NC

DEFINITIONS

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

Actively at Work* or *Active Work means that *You* must:

1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the *Schedule of Benefits*; and either:
 - a. work at the *Policyholder's* usual place of business; or
 - b. work at a location to which the *Policyholder's* business requires *You* to travel;
3. be paid regular earnings by the *Policyholder*, and
4. not be a temporary or seasonal Employee.

You will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Sickness*.

00061

Activities of Daily Living means:

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

00062

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

00066

Dependent or Eligible Dependent means:

1. *Your* lawful *Spouse* or *Registered 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 or child of *Your Registered Domestic Partner*.
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.

00072a

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

00073

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

00074

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

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

00078

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

00081

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

00082

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

00083

Male Pronoun whenever used includes the female.

00088

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

00089

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

00092

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

00097

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

00098 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

Public Safety Officer means a person whose primary job duties include controlling or reducing crime, criminal law enforcement and fire suppression.

00102

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
7. 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 means 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 Dearborn Life Insurance Company, Chicago, Illinois.

00119

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

00120

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 and Health Maintenance Organizations (HMOs) 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 or HMO 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 the 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 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.

North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks Rd Ste 106-153
Raleigh, North Carolina 27609-5729
<https://www.nclifega.org/>

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 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 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 or HMO. 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 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;
- They acquired rights to receive payments through a structured settlement factoring transaction.

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;
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

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 out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to a health benefit plan.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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 employer, Your union, or any other person, 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.

3. Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such 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 a federal court. The court will decide who should pay court 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 if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have questions about this statement or about rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

ERISA INFORMATION STATEMENT

The benefits described in your certificate are insured by an Insurance Policy ("Policy") issued by Dearborn Life Insurance Company ("We" or "Insurer"), pursuant to an "employee welfare benefit plan" ("the Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1), established by your employer, or where applicable, employee organization (the "Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity 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 the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. 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. As stated above, the Plan's benefits are provided to you pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- 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), 29 U.S.C. §1105(a). The Employer makes no promise to continue these 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, except as provided in the Plan.

B. CLAIMS PROCEDURE FOR LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Dearborn Life Insurance Company
701 E. 22nd Street
Lombard, IL. 60148
1-800-721-7987

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

Insurance Plans

We 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.

If the claim is denied, in whole or in part, We will provide You with a written notice giving the following:

- the reasons for the adverse benefit determination;
- reference to the specific Policy provisions on which the determination is based;
- a description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of Your rights to bring a civil action under ERISA §502(a), 29 U.S.C. §1132(a) following an adverse benefit determination on review.

Any denied claim may be appealed to the Insurer by You or Your authorized representative, at the address specified in the claim denial, for a full and fair review. The review will be conducted by a person different from the person who made the initial decision and the reviewer will not review the merits of the claim with the original examiner nor be the original examiner's subordinate. 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. We will notify You in writing if an extension is needed. If We need information from You and You deliver that information within the time specified, the extension will begin after You provide the information. If You do not provide the information in that time period, We may decide Your appeal without that information. 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, 29 U.S.C. §1132(a).

C. CLAIMS PROCEDURE FOR WAIVER OF PREMIUM BENEFITS:

When You are eligible to receive benefits, You must follow the claim procedures described in your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department
Dearborn Life Insurance Company

701 E. 22nd Street
Lombard, IL. 60148
1-800-721-7987

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

We 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, We notify 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, We will provide You with a written notice giving the following:

- the reasons for the adverse benefit determination;
- reference to the specific Policy provisions on which the determination is based;
- a description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied on in making the adverse determination or, alternatively, a statement that such rules, guideline, protocols, standards or other similar criteria of the Plan do not exist;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of Your rights to bring a civil action under ERISA §502(a), 29 U.S.C. §1132(a) following an adverse benefit determination on review.

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 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.

We 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, We notify 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.

If the adverse benefit determination is upheld on administrative appeal, in whole or in part, We will provide You with a written notice giving the following:

- the reasons for the adverse benefit determination;
- reference to the specific Policy provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied on in making the adverse determination or, alternatively, a statement that such rules, guideline, protocols, standards or other similar criteria of the Plan do not exist;

- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of Your rights to bring a civil action under ERISA §502(a), 29 U.S.C. §1132(a) following an adverse benefit determination on review.

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148