Zurich American Life Insurance Company

Benefits Schedule

Term Life Insurance

GENERAL INFORMATION

The coverages shown in this Certificate of Coverage are provided under a Group Insurance *Policy* issued by Zurich American Life Insurance Company to the *Policyholder*. The *Policy* governs all the coverages and payment of benefits shown in the Certificate. If a provision or term in the Certificate conflicts with a provision or term found in the *Policy*, the *Policy's* provision or term controls. *You* may examine the Group Insurance *Policy* at the principal office of the *Policyholder* during regular working hours.

This Certificate and/or Benefits Schedule replace any and all Certificates and/or Benefits Schedules previously issued to *you* under the Group Insurance *Policy*.

Policyholder: Activision Blizzard
Policy Number: CLPEX01033
Policy Effective Date: January 1, 2017
Plan Year: January 1, 2017 through December 31, 2017 and each following January 1st.

Eligible Classes: All persons in the following class(es) are eligible for *employee* coverage:

Class 1: All active, *full-time employees* of Activision Publishing, Inc. (and any of its subsidiaries and other affiliates) on the US payroll system regularly working a minimum of 30 hours per week, excluding all other *employees* classified as Executive.
Class 2: All active, *full-time employees* of Activision Publishing, Inc. (and any of its subsidiaries and other affiliates) on the US payroll system regularly working a minimum of 30 hours per week, classified as Executive.

Minimum Hours Requirement:

Full-Time Employees: *Employees* must be working at least 30 regularly scheduled hours per week.

Service Waiting Period:

Full-Time Employees: For *employees* in an *eligible class* on or before the *Policyholder's* effective date: First day of the month coincident with or next following the date of hire.
For *employees* in an *eligible class* after the *Policyholder's* effective date: First day of the month coincident with or next following the date of hire.

Who Pays For the Coverage:

Basic Life Plan:
Your employer pays the cost of *your* coverage.
Supplemental Plan:
You pay the cost of *your* coverage.
For Your Dependents: Supplemental Plan
You pay the cost of *your* coverage.

Elimination Period:

Premium Waiver: 9 months
Disability-based benefits begin the day after *we* approve *your* claim and the *elimination period* is completed.

BENEFITS SCHEDULE Term Life Insurance	
Employee Basic Plan	
Eligible Classes:	**Life Insurance Amount:**
Class 1: Class 2:	2 x *Annual Earnings* 3 x *Annual Earnings*
All amounts are rounded to the next higher multiple of $1,000 if not already an exact multiple thereof. *Annual earnings* are determined by *your employer*. *Annual earnings* are defined in the Glossary.	
Maximum Benefit Amount:	
Class 1: Class 2:	The lesser of 2 x *Annual Earnings* or $1,000,000 The lesser of 3 x *Annual Earnings* or $1,000,000
Guarantee Issue Amount:	
Class 1: Class 2:	The lesser of 2 x *Annual Earnings* or $1,000,000 The lesser of 3 x *Annual Earnings* or $1,000,000

EMPLOYEE TERM LIFE INSURANCE

Supplemental Plan

An *employee* must be insured for basic life insurance in order to become insured for supplemental life insurance.

Eligible Classes:	**Employee Life Insurance Amount:**
Class 1 and Class 2:	1-5 x *Annual Earnings* to $1,000,000

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof. *Annual earnings* are determined by *your employer*. *Annual earnings* are defined in the Glossary.

Maximum Benefit Amount:

Class 1 and Class 2:	The lesser of 5 x *Annual Earnings* or $1,000,000

Minimum Benefit Amount:

Class 1 and Class 2:	$10,000

Guarantee Issue Amount:

Class 1 and Class 2:	The lesser of 3 x *Annual Earnings* or $250,000

You may elect coverage under any one of the available options shown above for Supplemental Term Life Insurance. Once *you* have selected *your Plan* option, if *you* wish to make a change, *your employer* can provide *you* with information on how and when changes can be made.

AUTOMATIC INCREASE FEATURE

If *your* supplementary life insurance benefit is based on *annual earnings*, it will automatically increase up to $25,000 if the *employer* provides *us* with the required notice of an increase in *annual earnings*, and *you* are *actively at work* on the effective date of the increase. If *you* are not *actively at work* on that date, the benefit will not increase until *you* return to active work. If *you* revoke this Automatic Increase Feature, it may not be elected at a later date. If *you* have not enrolled for the Automatic Increase Feature, *evidence of insurability* must be provided before any increase based on an increase in *annual earnings* becomes effective.

Evidence of Insurability

Evidence of insurability is required for any amount of insurance over the Guarantee Issue Amount of $250,000.

Evidence of insurability is required if *you* request life insurance coverage more than 31 days after the *eligibility date*.

Evidence of insurability is not required for *amounts of life insurance you* had in force with *your employer's* prior carrier on the termination date of the prior carrier's plan.

Evidence of insurability is required for *amounts of life insurance* in excess of the greater of:

- the *amount(s) of life insurance you* had in force with *your employer's* prior carrier on the termination date of the prior carrier's plan; or
- the *amount(s) of life insurance* over the amount shown above.

If *we* do not approve *your evidence of insurability*, the *amount of life insurance* will be limited to the Guarantee Issue Amount.

Life Status Changes: In addition to the Guarantee Issue Amount available to an *employee* when first eligible, an *employee* who experiences a *life status change* will be eligible to add supplemental coverage at one times *annual earnings*, without *evidence of insurability*. In order to receive this additional Guarantee Issue insurance, application must be made within 31 days of the *life status change* and the *employee* must not have previously been declined for any amount of insurance due to failure to provide satisfactory *evidence of insurability* when required.

Age Reduction Rules For Insurance Benefits

The age reduction rule effects the amount of insurance available if *you* become insured at certain ages or have reached certain ages while insured under this *Plan.*

Age Reduction Schedule

Age:	Reduced By:
65 to 69	35%
70 to 74	55%
75 to 79	70%
80 and over	80%

If *your* benefit is a percentage of *your* salary, the benefit reduction will be based on the value of *your Policy* the day before the next reduction period. If *your* benefit is a dollar amount, the original benefit amount will continue to be reduced by the percentages stated above, as *you* age.

After a reduction occurs, there will be no further increases in *your amount of life insurance*.

If *you* become insured during or after the month in which *you* reach the above ages, *your* life insurance amount will be the applicable percentage of the amount shown for *your eligible class.*

DEPENDENT TERM LIFE INSURANCE	
Supplemental Plan A *dependent's eligibility date* is the date *you* can first elect coverage for a *dependent*.	
Eligible Dependents:	**Life Insurance Amount:**
Spouse or Domestic Partner:	Units of $1,000 to the lesser of $500,000 or 100% of the ***employee's*** amount.
Age Reduction Rule: The amount of *your* ***spouse's*** or domestic partner's age life insurance will reduce by the same percentage or amount as *your* life insurance reduces. After a reduction occurs, there will be no further increases in the amount of *your* ***spouse's*** or domestic partner's age life insurance. The age reduction for your *spouse* or domestic partner is based on the ***spouse's*** or domestic partner's age, not the ***employee's*** age.	
Each Dependent Child:	
Age Schedule: Live birth to 19 years or to age 26:	$2,000, $5,000, $10,000 or $25,000
The amount of insurance for a *dependent* will not be more than 100% of the amount of *your* insurance amount under this *Plan*.	
Maximum Benefit Amount:	
Spouse or Domestic Partner:	The lesser of $500,000 or 100% of the *employee's* amount.
Dependent Child:	$25,000
Minimum Benefit Amount:	
Spouse or Domestic Partner:	$1,000
Dependent Child:	$2,000
Guarantee Issue Amount:	
Spouse or Domestic Partner:	$25,000
Dependent Child:	$25,000

Dependent Evidence of Insurability

Note: When eligible, *you* may increase *your dependent spouse or* domestic partner coverage by one additional increment(s) of up to $1,000 without having to submit *evidence of insurability* to *us,* as long as the total benefit amount does not exceed the Guarantee Issue Amount. This applies even if, in the past, *we* have approved *your dependent spouse's or* domestic partner's *evidence of insurability.*

Evidence of insurability is required for any amount of *your spouse's or* domestic partner's insurance over $25,000.

Evidence of insurability is required if *you* request life insurance coverage for a *dependent spouse or* domestic partner more than 31 days after the *dependent eligibility date.*

Evidence of insurability is not required for *amounts of life insurance your dependent spouse or* domestic partner had in force with *your employer's* prior carrier on the termination date of the prior carrier's plan.

Evidence of insurability is required for *amounts of life insurance* in excess of the greater of:

- the *amount(s) of life insurance you* had in force with *your employer's* prior carrier on the termination date of the prior carrier's plan; or
- the *amount(s) of life insurance* over the amount shown above.

If *we* do not approve *your dependent spouse's or* domestic partner's *evidence of insurability*, the *amount of life insurance* will be limited to the Guarantee Issue Amount.

Accelerated Death Benefit	
Employee and Spouse or Domestic Partner:	
Accelerated Death Benefit Minimum:	$5,000
Accelerated Death Benefit Maximum:	$500,000
Accelerated Death Benefit Percentage:	80%

Limitations and Exclusions Which Apply to Your Coverage:

This Benefits Schedule summarizes some of the features and benefits of *your employer's* term life *Plan.* It is not a contract. For a complete description of the terms, conditions, exclusions and limitations of *your employer's Plan*, refer to *your* Certificate. In the event of a discrepancy between this Benefits Schedule and the Certificate, the Certificate will control.

Your amount of life insurance will be reduced by any life benefit:

- paid to *you* under an accelerated death benefit in the *prior plan* and in force for *you* under any disability extension provision of the *prior plan*;
- paid to *you* under an accelerated death benefit in this *Plan* or paid to *you* under any disability extension provision under this *Plan.*

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN. REFER TO THE EXCLUSIONS SECTION OF THE CERTIFICATE FOR A COMPLETE LIST OF EXCLUSIONS.

Zurich American Life Insurance Company

Certificate of Coverage

Term Life Insurance Plan

Policyholder: Activision Blizzard
Policy Number: CLPEX01033

Zurich American Life Insurance Company is pleased to welcome *you* to the *Plan*. This is *your* Certificate of Coverage, referred to as "Certificate", as long as *you* are eligible for coverage and *you* meet the requirements for becoming insured. *You* will want to read this Certificate carefully and keep it in a safe place.

Throughout this document the words "*we", "our", "us*", and "the Company" means Zurich American Life Insurance Company. The words "*you*" and "*your*" mean the insured *employee* and any covered *dependents*, of the *Policyholder* sponsoring this *Plan*. Some terms and provisions are written as required by insurance *law*. Important terms are defined in the Glossary Section of the Certificate. Defined terms appear in italic print. If *you* should have any questions about the content or provisions, please consult *us* electronically through *our* website or at the toll free number provided below. *We* will assist *you* in any way to help *you* understand *your* benefits.

The benefits described in this Certificate are subject in every way to the entire Group Insurance Policy. If the terms and provisions of the Certificate are different, the *Policy* will govern. The Group Insurance Policy includes this Certificate, the Benefit Schedule(s), and any riders or amendments issued with the Group Insurance Policy. The *Policyholder's* application and any application or *evidence of insurability* completed by *you* or on *your* behalf, when applying for coverage or an increase in coverage, are also considered part of the *Policy.*

This Certificate contains a benefit option for an Accelerated Death Benefit. The insurance benefit amount payable will be reduced by any Accelerated Death Benefit paid any *Insured* covered under this Certificate.

Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the *Policy.* The *Policy* is delivered in and is governed by the *laws* of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

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

Zurich American Life Insurance Company is located at:

1299 Zurich Way
Schaumburg, IL 60196

Our toll free number is: 877-856-2268
Outside the United States: 719-268-2416
Our website address is: www.zurichna.com

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Special Notices

DISCLOSURE NOTICES

For Residents of the Following States

INDIANA

NOTICE TO EMPLOYEES

Questions regarding *your Policy* or coverage should be directed to:

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
1-888-634-6780

If *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street
Suite 300
Indianapolis, IN 46204

Consumer Hotline:
1-800-622-4461

In the Indianapolis Area:
1-317-232-2395

Complaints can be filed electronically at www.in.gov/idoi

ARKANSAS

QUESTIONS OR PROBLEMS WITH YOUR POLICY?

If *you* have any questions or problems with *your Policy*, *you* may contact *us* at the address below or one of the other organizations listed:

Zurich American Life Insurance Company
7045 College Boulevard
Overland Park, Kansas 66211-1523
Telephone: (877) 678-7534

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2640 or (800) 852-5494

GEORGIA

NOTICE

The *laws* of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

ILLINOIS

NOTICE TO EMPLOYEES - ILLINOIS

This notice is to advise *you* that should any complaints arise regarding this insurance, *you* may contact the following:

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
(888) 634-6780

For *your* information, the following is *your* state's Department of Insurance contact information:

Illinois Department of Insurance
Consumer Division
320 W Washington St
Springfield, IL 62767
(217) 782-4515

WISCONSIN

NOTICE TO EMPLOYEES – WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If *you* are having problems with *your* insurance company or agent, do not hesitate to contact the insurance company or agent to resolve *your* problem.

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
(888) 634-6780

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance *laws*, and file a complaint. *You* can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
Toll-Free: (800) 236-8517
Telephone: (608) 266-0103

Zurich American Life Insurance Company

Toll Free Number:	877-856-2268
Claim Information Toll Free Number:	877-856-2268
Outside the United States:	719-268-2416

Important Information Regarding The Availability Of Coverage

No benefits are covered under this Certificate in the absence of payment of current premiums subject to the *grace period* and the Premium Section of the Group Insurance Policy. Unless specifically provided for in any applicable termination or continuation of coverage provision, described in this Certificate or under the terms of the Group Insurance Policy*,* this *Plan* does not pay benefits for the loss of life, an *accident* or a disability incurred before coverage starts under this *Plan*. This *Plan* will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this *Plan* as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses incurred that start on or after the effective date of the *Plan* modification. There are no vested rights to receive any benefits described in the Group Insurance Policy or in this Certificate beyond the date of termination or renewal including if the loss, *accident* or disability starts on or after the effective date of the *Plan* modification, but prior to *your* receipt of amended *Plan* documents.

Fraud Notice

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

GENERAL PROVISIONS

Zurich American Life Insurance Company

Your Life Insurance Plan
(the "*Plan*")

What Is The Certificate?

This Certificate of Coverage ("Certificate") is a written document prepared by Zurich American Life Insurance Company. *We* have provided *you* this Certificate of Coverage ("Certificate") to tell *you* about important *Plan* information such as:

- the coverage to which *you* may be entitled;
- claim processing and administrative procedures;
- to whom *we* will make a payment; and
- the limitations, exclusions and requirements that apply within the *Plan*.

The Certificate may include attachments such as amendments and riders, which describe additional provisions about *your Plan*. Please carefully read all the documents *we* provide *you* to fully understand *your Plan*.

Eligibility

Who Is Eligible For Coverage?

To be eligible for coverage under this *Plan*, the following requirements must be met:

- *you* must be employed by the *Policyholder*; and
- *you* must be in *active employment*;
- *you* must be in an *eligible class*; and
- *you* must be working inside the United States.

Dependent Coverage

If *you* elect coverage for yourself or are insured under the *Plan*, *you* are eligible to elect *dependent* coverage for *your dependents*. Refer to Dependent Coverage Section of this Certificate for information on *dependent* eligibility and how to enroll *your dependents*.

Determining Your Eligible Class

Your employer determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions related to *your* employment.

The criteria describing *eligible classes* of *employees* are listed on the Benefits Schedule attached to this Certificate. Refer to the Benefits Schedule or contact *your employer* to determine if *you* are in an *eligible class*.

When Are You Eligible For Coverage?

If *you* are working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the later of:

- the *Plan* effective date; or
- the day after *you* complete *your service waiting period,* if any.

Once *you* are eligible for coverage, *your* coverage will begin in accordance with the provisions of the Section entitled *"*When Does Your Coverage Begin?*"*

New Hires

If *you* are in an *eligible class* on the date of hire, *your eligibility date* is the later of the date *you* are hired or the date *you* complete the *service waiting period.* If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* complete *your service waiting period*. If *you* have already satisfied the *service waiting period* with the *Policyholder* before *you* enter the *eligible class*, *your eligibility date* is the date *you* enter the *eligible class*.

What Is A Service Waiting Period?

Once *you* enter an *eligible class, you* will need to complete the *service waiting period* before *your* coverage under the *Plan* begins. The *service waiting period* is the continuous length of time that *you* must be in *active employment* and in an *eligible class* before *you* are eligible for coverage under this *Plan*. The *service waiting period* is shown on the Benefits Schedule.

Except as noted in the "Reinstatement Provision", if *you* terminate this insurance and later wish to reapply, or if *you* are a former *employee* who is rehired, a new *service waiting period* must be satisfied.

Effective Date Of Coverage

When Does Your Coverage Begin?

Basic Plan
When *your employer* pays 100% of the cost of *your* coverage under a *Plan*, *your* coverage will begin at 12:01 a.m. Central Standard Time on the 1st day of the month following the date on which *you* are eligible for coverage.

Supplemental Plan
You pay 100% of the cost of *your* coverage under a *Plan*. Once *you* are eligible for coverage, *you* have 31 days from the date *you* become eligible to apply for coverage.

Your coverage will begin at 12:01 a.m. Central Standard Time on the later of:

- the 1st day of the next month following the date *you* are eligible for coverage, if *you* apply for insurance on or before that date for any amount of insurance that is not subject to *evidence of insurability* requirements; or
- the 1st day of the next month following the date *you* apply for insurance, if *you* apply within 31 days after *your eligibility date*, for any amount of insurance that is not subject to *evidence of insurability* requirements; and

- the 1st day of the next month following the date *we* approve *your evidence of insurability* form, if *you* apply for insurance on or before *your eligibility date* or within 31 days after *your eligibility date*, for any amount of insurance that is subject to *evidence of insurability* requirements.

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

Evidence of insurability is required for any *amount of life insurance* over the amount shown in the Life Insurance Benefits Schedule.

Deferred Effective Date

If *you* are absent from work due to *injury*, *sickness*, temporary *layoff* or *leave of absence* on the date *your* insurance would otherwise become effective, *your* coverage, increase in coverage or new benefits will begin the date *you* return to *active employment*.

Enrollment

How Do You Enroll For Coverage?

You will be provided with *Plan* design and enrollment information when *you* first become eligible. If *you* are not required to contribute towards the cost of coverage, *you* are not required to request coverage or complete an enrollment form. *Your* enrollment will be handled by *your employer*.

However, *you* are required to enroll for supplemental coverage.

If *you* must contribute towards the cost of coverage or *you* elect to purchase additional coverage at the time of enrollment, *you* are required to enroll for coverage. To do so *you* must complete and sign a group insurance enrollment form, satisfactory to *us,* and deliver it to *your employer*.

You must enroll on a group insurance enrollment form approved and provided by *us*. If an *evidence of insurability* application is required, *you* must complete it in accordance with the instructions below.

When Do You Enroll?

If *you* are required to enroll for *your* insurance, *you* will need to enroll within 31 days of *your eligibility date*. Otherwise, *you* may be considered a *late applicant*. If *you* miss the enrollment period, *you* will not be able to participate in the *Plan* until:

- *you* complete the requirements for a *late applicant* described below; and
- *we* approve *you* as a *late applicant;* or
- until the next enrollment period.

Late Applicant Enrollment Requirements

If *you* do not enroll for coverage within 31 days after becoming eligible, but wish to do so later, *your employer* will provide *you* with information on when and how *you* can enroll as a *late applicant*.

IMPORTANT NOTE: As a *late applicant*, *you* may be denied coverage if *your evidence of insurability* is not satisfactory to *us*, the effective date of *your* coverage may be delayed or *your* benefits may be reduced.

You must complete an enrollment form and submit *evidence of insurability* to *us*. *Evidence of insurability* is required for any amount of insurance. *We* will review the information and solely determine *your eligibility date*. *We* will notify *you* and *your employer* of *our* decision.

When Is Evidence Of Your Insurability Required?

Evidence of insurability is not required for the Guarantee Issue Amount.

Evidence of insurability means a statement of *your* medical history which *we* will use to determine if *you* are approved for coverage or an increase in coverage. This requirement will be met when *we* decide the *evidence of insurability* is satisfactory. An *evidence of insurability* form can be obtained from *your employer.*
If *you* are required to submit *evidence of insurability*, *you* must:

- complete and sign a health and medical history form provided by *us*;
- submit to a medical examination, if requested;
- provide any additional information that *we* require including verification of earnings and attending *physicians*' statements; and
- furnish all such evidence at *your* own expense.

Evidence of Insurability (EOI) is required if *you:*

- enroll for coverage for the first time above the Guarantee Issue Amount shown in the Benefits Schedule;
- re-enroll for coverage after *your* coverage ends for any reason;
- enroll for an increase in *your* coverage above the Guarantee Issue Amount. *You* must complete new *evidence of insurability* each time *you* request an increase. This applies even if *we* have approved evidence *of your* insurability in the past. *We* may deny *your* increase if the *evidence of insurability* is not satisfactory to *us*;
- are a *late applicant*, which means *you* apply for coverage more than 31 days after the date *you* are eligible for coverage;
- voluntarily cancelled *your* coverage and are reapplying;
- did not make the required contributions and *your* coverage was cancelled;
- were eligible but not enrolled for any group life coverage sponsored by *your employer* on the day before the effective date of this *Plan*;
- enroll on the effective date of this *Plan* for an amount of coverage that is greater than the amount of coverage *you* had in effect under any group life coverage sponsored by *your employer* on the day before the effective date of this *Plan*;
- elect on the effective date of this *Plan,* to increase the amount of *your* life coverage that was in effect under prior coverage. *We* may deny *your* increase if the *evidence of insurability* is not satisfactory to *us*;
- have not met a previous evidence requirement to become insured under any *Plan* the *employer* has with *us*.

The *Policyholder* may not waive the *evidence of insurability* requirement for any reason.

If *your evidence of insurability* is not acceptable to *us*, *you* will not be covered under this *Plan*. This rule also applies to *your* request for an increase in coverage and *your* increase will not be covered.

Annual Enrollment Period

During the *annual enrollment period*, *you* will have the opportunity to review *your* coverage needs for the upcoming year. *Your employer* and the Company determine when the *annual enrollment period* begins and ends. During this period, *you* have the option to apply for insurance, change *your* coverage or apply for an increase in *your* insurance. The choices *you* make during this *annual enrollment period* will become effective the following *Plan* year as indicated on the Benefits Schedule.

Automatic Increase Feature

If *your* supplementary life insurance benefit is based on *annual earnings*, it will automatically increase up to $25,000 if the *employer* provides *us* with the required notice of an increase in *annual earnings*, and *you* are *actively at work* on the effective date of the increase. If *you* are not *actively at work* on that date, the benefit will not increase until *you* return to active work. If *you* revoke this Automatic Increase Feature, it may not be elected at a later date. If *you* have not enrolled for the Automatic Increase Feature, *evidence of insurability* must be provided before any increase based on an increase in *annual earnings* becomes effective.

After Coverage Begins

When May You Elect To Change Your Coverage?

You will need to contact *your employer* to determine when *you* may increase or decrease *your* coverage. *Your employer* will provide *you* with information and forms *you* need to initiate the process. *Your employer* will notify *us* of the date of the change.

You must provide *us* with *evidence of insurability* if *you*:

- did not enroll for supplemental life insurance when *you* first became eligible, and now want to enroll; or
- would like to increase the amount of *your* supplemental life coverage.

Life Status Changes

You may elect or increase coverage within 31 days after *you* have a *life status change*. A *life status change* is an event that qualifies *you* to make changes in benefit selections at a time other than an *annual enrollment period*. Changes in coverage must be appropriate and consistent with the change in status. The following events are *life status changes*:

- marriage;
- divorce, annulment or legal separation;
- birth or adoption of a child or becoming a legal guardian of a child;
- death of a *spouse*;
- the death or emancipation of a child;
- termination of a *spouse's* employment;
- a change in the benefit *Plan* available to *your spouse*;
- a change in *your* or *your spouse's* employment status that affects either person's eligibility for benefits;
- a change in classification from *part-time* to *full-time* or from *full-time* to *part-time.*

A change in coverage due to a *life status change* will begin at 12:01 a.m. Central Standard Time on the latest of:

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

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

When Will Changes To Your Coverage Take Effect?

Once *your* coverage begins, any increased or additional coverage will take effect on the later of the *Policy* anniversary date or on the date *your evidence of insurability* is approved by *us*, if *evidence of insurability* is required.

You must be in *active employment* or on a covered *layoff* or *leave of absence.*

Any decrease in coverage will take effect immediately.

Neither an increase nor a decrease in coverage will affect a *payable claim* that occurs prior to the increase or decrease.

Deferred Effective Date For An Increase In Coverage

If *you* are not in *active employment* due to *injury* or *sickness,* any increased or additional coverage will begin on the date *you* return to *active employment*.

How Do You Pay For Your Coverage?

We will bill *your employer* for the premium and any amount *you* owe. *Your employer* will pay the premium on *your* behalf.

Your employer may require *you* to pay a portion for or all of the cost of *your* insurance. *Your employer* will determine the amount of *your Plan* contributions, if any. *Your employer* will advise *you* of the required amount of *your* contributions and inform *you* of any required payroll deductions.

When Coverage Ends

When Does Your Coverage End?

Your coverage under this *Plan* ends on the earliest of:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* voluntarily stop *your* coverage;
- the date *you* are no longer in an *eligible class;*
- the date *your eligible class* is no longer covered;
- the last day of the period for which *you* made any required contributions;
- the last day *you* are in *active employment;*
- the date *your* employment stops for any reason, including job elimination, or being placed on severance. This will be either the date *you* stop *active employment*, or the day before the first premium due date that occurs after *you* stop *active employment*;
- the date on which *you* retire;
- the date of *your* death; or

- the date on which *you* begin active duty in the armed forces of any country.

When Will Your Coverage Continue If You Are Temporarily Not Working?

If premium payments continue to be made on *your* behalf, *we* may deem *your* employment to continue for purposes of remaining eligible for coverage under this *Plan* as described below:

If *you* are not in *active employment* due to temporary *layoff or leave of absence,* sabbatical or other authorized leave as agreed to by *your employer* and *us*, *your* coverage may continue up to a maximum of three (3) months from the start of *your* absence.

Continued coverage is subject to any reductions in the *Policy* and terminates when the *Policy* terminates.

What Happens To Coverage While You Are On A Family And Medical Leave Of Absence Or A Military Leave Of Absence?

Coverage will be continued until the end of the later of:

- the leave period required by the Federal Family and Medical Leave of Absence Act of 1993 and any amendments; or
- the leave period required by applicable national, state or local *law*, or any similar *law*, *plan* or *act*; or
- if the *Policyholder's Policy* does not provide for continuation of *your* coverage during a family and medical *leave of absence*, *your* coverage will be reinstated when *you* return to *active employment*.

If *you* return to work within six (6) months, *we* will not:

- apply a new s*ervice waiting period*; or
- require *evidence of insurability*.

For the above exceptions to apply, *you* must request to reinstate contributory coverage within 31 days of *your* return to *active work*.

Reinstatement Of Coverage

If *your* coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin" Section. If *we* approve *your* request, the reinstatement will be effective on the first day of the month coinciding with or following the approval date. *We* will notify *you* of *your* reinstatement date.

If *you* return to *active employment* within six (6) months of the date *your* coverage terminated and *you* request coverage from *your employer* within 31 days of *your* return, the *service waiting period* requirement will apply only to the extent it would have applied if *your* coverage had not ended.

How Can Statements Made In Your Application For This Coverage Be Used?

In the absence of fraud, *we* consider any statements *you* or *your employer* makes in a signed application for coverage, or that *your employer* makes in the application process, a representation and not a warranty. If any of the statements *you* or *your employer* make are not complete and true at the time they are made, *we* may:

- reduce or deny any claim; or
- cancel *your* coverage from the original effective date or any increase in coverage.

If *we* use a statement to reduce, deny, or contest a claim, or cancel *your* coverage, a copy of that statement will be furnished to *you* or, in the event of *your* death or incapacity, to *your eligible survivor* or personal representative. *We* will use only statements made by the *employer* in the application process or statements made by *you* in a signed application as a basis for doing this. If the *Policyholder* gives *us* information about *you* that is incorrect, *we* will:

- use the true and correct facts to decide whether *you* have coverage under the *Plan* and in what amounts; and
- make a fair adjustment of the premium.

Our failure to implement or insist upon compliance with any provision of the *Policy* at any given time or times shall not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This applies whether or not the circumstances are the same.

Conversion Benefit

A life conversion option may be available without a medical exam if *you* apply for it within 31 days of *your* loss of coverage under this *Plan.* For more information about the Conversion Provision, refer to the "Conversion Policy" Section of this Certificate.

Incontestability Period

During the first two (2) years that *your* insurance is in force, *we* may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two (2) years that follow the effective date of that increase, if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two (2) years, the validity of *your* insurance may not be contested by *us*.

Recovery Of Overpayments

If payments are made in amounts greater than the benefits that *you* are entitled to receive, *we* have the right to recover any overpayments. Refer to the Claim Information Section for the process *we* use to recover overpayments.

How We Handle Insurance Fraud

We have the right and will to use all means available to *us* to detect, investigate, deter and prosecute those who commit insurance fraud. *We* also have the right to pursue all legal remedies if *you* and/or *your employer* perpetrate insurance fraud.

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any material fact concerning the coverage sought or payment of benefits.

It is a crime if *you* or the *Policyholder* commit insurance fraud and *you* or the *Policyholder* may be subject to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or

termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and penalties.

Does The Policyholder Act As Our Agent?

No. For purposes of the *Policy*, the *Policyholder* acts on its own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

Non-Participation Policy

This *Policy* is not entitled to share in surplus distribution.

Dependent Coverage

Dependent Eligibility For Insurance

Your dependent(s) can be covered under this *Plan*. If *you* elect coverage for yourself or are insured under this *Plan*, *you* are eligible to elect *dependent* coverage as described below for *your dependents.*

Your dependents are eligible for coverage the later of:

- the date *your* insurance begins;
- the date *you* first acquire a *dependent*.

It is important that *you* inform *your employer* when *you* first acquire a qualified *dependent*. *We* will rely upon *your employer* to determine if a person meets the definition of a *dependent* for coverage under the *Plan*. This determination will be conclusive and binding upon all persons for purposes of this *Plan.*

What Dependents Are Eligible For Coverage?

The following *dependents* are eligible for coverage under the *Plan*:

- *your* lawful *spouse*. *You* may not cover *your spouse* as a *dependent* if *your spouse* is enrolled for coverage as an *employee*;
- *spouse* wherever used includes domestic partner;
- *your* domestic partner is the person named in *your* declaration of domestic partnership. *You* must execute and provide the *Plan Administrator* with such a declaration that states and gives proof that the domestic partner has had the same permanent residence as *you* for a minimum of six (6) consecutive months prior to the date insurance would become effective for that domestic partner. *You* must not have signed a declaration of domestic partnership with anyone else within the last six (6) months of signing the latest declaration of domestic partnership. Also, the domestic partner must be at least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named domestic partner, not married to anyone else and the declaration of domestic partnership must be approved and recorded by the *Plan Administrator*. *You* may not cover *your* domestic partner as a *dependent* if *your* domestic partner is enrolled for coverage as an *employee*;
- *your* unmarried children from live birth, but less than age 26. Stillborn children are not eligible for coverage;
- *your* unmarried *dependent* children age 19 or over, but under age 26 also are eligible;
- *your* unmarried *dependent* children age 26 or over, are eligible, provided they are unable to earn a living because of a physical or mental disability and *you* are the main source of support and maintenance;
- *your* unmarried *dependent* children age 26 or over who are permanently and continuously incapable of self-sustaining support by reason of mental retardation or physical handicap existing prior to the child's attainment of age 26.

We must receive proof within 31 days of the date the child is eligible for coverage under this *Policy,* and as required during the first two (2) years. After the first two (2) years, *we* will ask for proof when needed, but not more than once a year.

Dependent Children

Children include *your* own biological children, lawfully adopted children. They also include:

- stepchildren;
- *your* domestic partner's children;
- A grandchild who is unmarried, younger than 26 years of age; and
- a *dependent* of the *Insured for* federal income tax purposes at the time of application or in *your* court-ordered custody.

A child is considered adopted on the date of placement in *your* home.

No *dependent* child may be covered by more than one *employee* in the *Plan.* No *dependent* child can be covered as both an *employee* and a *dependent*.

When Dependent Coverage Begins

You pay 100% of the cost of *your dependent* coverage under a *Plan*. Once *you* are eligible for *dependent* coverage, *you* have 31 days from the date *your dependents* become eligible to apply for *dependent* coverage. *Dependent* children are not subject to the *evidence of insurability* requirements.

Your dependent coverage will begin at 12:01 a.m. Central Standard Time on the later of:

- the first of the month following the date *your dependents* are eligible for coverage, if *you* apply for *dependent* insurance on or before that date, for any amount of insurance that is not subject to *evidence of insurability* requirements; or
- the first of the month following the date *you* apply for *dependent* insurance, if *you* apply within 31 days after *your dependent's eligibility date* for any amount of insurance that is not subject to *evidence of insurability* requirements; and
- the first of the month following the date *we* approve *your dependent's evidence of insurability* form, if *you* apply for *dependent* insurance on or before *your dependent's eligibility date* or within 31 days after *your dependent's eligibility date*, for any amount of insurance that is subject to *evidence of insurability* requirements.

Evidence of insurability is required if:

- *your spouse* or *domestic partner* is a *late applicant*, which means *you* apply for *spouse* or *domestic partner* coverage more than 31 days after the date *your spouse* or domestic partner is eligible for coverage; or
- *you* voluntarily cancelled *your spouse* or domestic partner coverage and are reapplying; or
- *you* declined *your spouse* coverage and now are applying; or
- *you* are applying for any amount of *dependent* life insurance for a domestic partner.

Evidence of insurability is also required for any amount of *spouse* or domestic partner life insurance over the amount shown in the Life Insurance Benefits Schedule. An *evidence of insurability* form for *your dependents* can be obtained from *your employer*.

Dependents Who Are Late Applicants

You can apply for *dependent spouse, domestic partner or dependent child(ren)* coverage at any time during the *Plan* year. *Evidence of insurability* is not required for any amount of *child(ren)* life insurance applied for by *you*.

Your employer determines with *us* when the *annual enrollment period* begins and ends.

Dependent spouse or *domestic partner* coverage will begin at 12:01 a.m. Central Standard Time on the first of the month following the first of the month coincident with or next following the date *your dependent spouse's* or *domestic partner's evidence of insurability* form is approved or *we* approve *your dependent's evidence of insurability* form.

Delay Of Effective Date

A qualified *dependent* may be *confined* for medical care or treatment at home or elsewhere. If a qualified *dependent* is so *confined* on the day that *your dependent's* insurance under a coverage for that qualified *dependent*, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified *dependent's* final medical release from all such *confinement*. The other requirements for the insurance or change must also be met.

Newborn Child Exception

This section does not apply to a child of *yours* if the child is born to *you*, becomes *your* qualified *dependent* at birth, and either:

- is *your* first qualified *dependent*; or
- becomes a qualified *dependent* while *you* are insured for *dependent's* insurance under that coverage for any other qualified *dependent.*

Also this section does not apply to any age increase in the amount of insurance for a child under the *dependent's* life coverage.

Changing Your Dependent Life Insurance Coverage

You can increase *your dependent spouse* or *domestic partner* coverage any number of benefit units up to the maximum benefit available under the *Plan. Evidence of insurability* is required for any amount of *dependent spouse* or *domestic partner* life insurance applied for by *you*.

Changes in *dependent spouse* or *domestic partner* coverage that are made during a *Plan* year will begin at 12:01 a.m. Central Standard Time on the first of the month following the date *your dependent spouse's* or *domestic partner's evidence of insurability* is approved.

You can increase *your child(ren)* coverage by any number of benefit units up to the maximum benefit available under the *Plan*. *Evidence of insurability* is not required for any amount of *child(ren)* life insurance applied for by *you*.

Changes in *dependent child(ren)* coverage that are made during a *Plan* year will begin at 12:01 a.m. Central Standard Time on the first of the month following the date of the change.

Dependents Who Are Totally Disabled On The Date Coverage Would Normally Begin

If *your* eligible *dependent* is *totally disabled*, *your dependent's* coverage will begin on the date *your* eligible *dependent* no longer is *totally disabled*. This provision does not apply to a newborn child while *dependent* insurance is in effect.

Effective Date Of Changes To Dependent Coverage

Once *your dependent's* coverage begins, any increased or additional *dependent* coverage will take effect the date *we* approve *your dependent's evidence of insurability* form, if *evidence of insurability* is required, provided *your dependent* is not *totally disabled*. *You* must be in *active employment* or on a covered *layoff or leave of absence*.

If *you* are not in *active employment* due to *injury* or *sickness*, any increased or additional *dependent* coverage will begin on the date *you* return to *active employment*.

If *your dependent* is *totally disabled*, any increase or additional coverage will begin on the date *your dependent* no longer is *totally disabled*.

Changes In Dependent Coverage

An increase or decrease in the amount of coverage for *your dependent*, as the result of a change in the *dependent's* age, status, or benefit level, will become effective on the date the age, status, or benefit level change occurs. If *you* are not *actively at work* on the date of the change, the increase in any coverage will be postponed until *you* return to work for one full day.

Any decreased coverage will take effect on the first of the month following the date *you* provide notification to *your employer*, but will not affect a *payable claim* that occurs prior to the decrease.

When Dependent Coverage Ends

Your dependent's coverage under the *Policy* or a *Plan* ends on the earliest of:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* no longer are in an eligible group;
- the date *your eligible class* is no longer covered;
- the date of *your* death;
- the last day of the period for which *you* made any required contributions; or
- the last day *you* are in *active employment* unless continued due to a covered *layoff* or *leave of absence* or due to an *injury* or *sickness;*
- or, due to retirement, as described in this Certificate.

Coverage for any one *dependent* will end on the earliest of:

- the date *your* coverage under a *Plan* ends;
- the date *your dependent* returns to the U.S.A. or country of residency to establish residency;
- the date *your dependent* ceases to be an eligible *dependent*;
- for a *spouse*, the date of divorce or annulment; or
- for a domestic partner, the date *your* domestic partnership ends.

Continuation Of Coverage For A Child Age 26 Or Over Who Become Disabled While Covered Under The Plan

Coverage will continue for a child age 26 or over who became physically or mentally disabled while covered under the *Plan* provided:

- the child is unmarried;
- the disability was acquired before the child's coverage would have ended;

- the child is incapable of self-support and remains so incapable; and
- *you* are the main source of support and maintenance.

Continuation Of Coverage For A Child Age 26 Or Over

Coverage will continue for a child age 26 or over who is permanently and continuously incapable of self-sustaining support by reason of mental disability or physical handicap, insured under the *Plan*, provided:

- the child is unmarried; and
- *you* are the main source of support and maintenance.

We must receive proof within 31 days of the date the child attains age 26 and as required during the first two (2) years. After the first two (2) years, *we* will ask for proof when needed, but not more than once a year.

Important Reminder: *You* cannot receive coverage under the *Plan* as both an *employee* and a *dependent*; or a *dependent* of more than one *employee*.

TERM LIFE INSURANCE BENEFITS

HOW THE PLAN WORKS

Life Insurance Benefits

Life insurance is an important component of *your* financial planning. This life insurance *Plan* pays a benefit to the named *beneficiary(ies)* if the *Insured* dies from any cause except as otherwise limited or excluded in this Certificate, while coverage is in effect.

A *life insurance benefit* is payable in the *amount of the life insurance benefit* shown on the Benefit Schedule for *you* upon written proof of death.

The benefit for *you* will be paid in accordance with the *beneficiary* rules of this Certificate.

The benefit for a covered *dependent* will be paid to *you*, if living, otherwise at *our* option *we* may pay the benefit to *your* surviving *spouse* or to the executors or *administrators* of *your* estate.

Beneficiary Rules

Choosing Your Beneficiary

You should choose *your beneficiary(ies)* as soon as *you* are covered under the *Plan*.

A primary *beneficiary* is the person *you* designate to receive life insurance benefits if *you* should die while *you* are covered under this *Plan*. The *beneficiary(ies) you* select will apply to all death benefits payable under the *Policy*. *You* may name anyone as *your beneficiary*. *You* may name more than one *beneficiary*. *You* will need to complete a *beneficiary* designation form, which *you* can get from the *Policyholder* or *us.*

If *you* name more than one primary *beneficiary*, benefits will be paid out equally unless *you* stipulate otherwise on the form. If *you* name more than one primary *beneficiary(ies)* and the amount or percentage of the payment to *your* primary *beneficiaries* does not equal 100% of *your* benefit amount, the difference will be paid equally to *your* named primary *beneficiary(ies).*

You may also name a contingent *beneficiary*. A contingent *beneficiary* is the person who will receive the *life insurance benefit* if there are no living primary *beneficiaries* at the time of *your* death.

It is important that *you* name *your beneficiary(ies)* and keep *your* designation current. If *you* do not name a *beneficiary*, or if all named *beneficiaries* do not survive *you*, or if *your* named *beneficiary* is disqualified, *your* death benefit may be paid to *your* estate or to surviving family members as described below.

In addition, if *you* do not survive *your spouse* or domestic partner and *dependent* life coverage is continued, then *your* surviving *spouse* should name a *beneficiary* according to the requirements specified for *you* in this Certificate.

Changing Your Beneficiary(ies)

You may change *your beneficiary* choice at any time by completing a new *beneficiary* designation form unless *you* have assigned this *Policy* to someone else. Send the completed form to the

Policyholder or to *us.* The *beneficiary* change will be effective on the date *you* sign a new *beneficiary* designation form.

Prior to *your* death, *you* are the only person who can name or change *your beneficiary*. No other person may change *your beneficiary* on *your* behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment unless the appointment specifically states that the agent may change the *beneficiary* under this *Plan*.

The Company will pay death benefits in accordance with the *beneficiary* designation *we* have on record. Any payment made before *we* receive *your* request for a *beneficiary* change will be made to *your* previously designated *beneficiary*. The Company will be fully discharged of its duties if the payment is made before *we* receive notification of a change in *beneficiary*.

If *you* wish to change *your beneficiary*, please contact *us* for a *beneficiary* change form.

If Your Beneficiary Dies Before You

If one of *your* named primary *beneficiaries* dies before *you*, his or her share will be payable in equal shares to any other named primary *beneficiaries* who survive *you*. If *you* have named a contingent *beneficiary*, *your* contingent *beneficiary* will only be paid if all primary *beneficiaries* die before *you*.

If *you* have not named a primary or contingent *beneficiary*, *we* have the right to make payment to the surviving family members instead of making payment to *your* estate in the following order:

- *your* surviving *spouse* or *your* registered domestic partner, if any;
- *your* child or in equal shares to *your* children;
- *your* surviving parents in equal shares;
- *your* brothers and sisters in equal shares; or
- if none of the above survives, to *your* estate.

If Your Beneficiary Is A Minor Or Lacks Legal Capacity

The method of payment will differ if *your beneficiary* is a minor or a person who lacks legal capacity to give *us* a valid release for payment of any death benefit. *We* will issue the payment, as permitted by applicable state *law* as follows:

- to the guardian of *your beneficiary's* estate; or
- the custodian of the *beneficiary's* estate under the Uniform Transfer to Minors Act; or
- an adult caretaker/legal guardian.

The Company will be fully discharged of its duties once *we* have paid *your* benefit. The Company is not responsible for how the payment is used.

Documents Required For Proof Of Death

We will require a certified copy of the death certificate and a completed proof of claim form. Refer

to the life insurance "Claim Information" Section of this Certificate for information on the documentation needed and the procedure to file a claim for benefits.

Payment Of Benefits

For Your Claim
Your beneficiary(ies) will receive payment within two (2) months of *our* receipt of the necessary written proof supporting the death claim. Refer to the Life Claim Information section in this certificate for information on the required documentation and process to file a claim. Benefit payments for *your* life insurance are made in a lump sum.

If *you* do not survive *your spouse*, and *dependent* life coverage is continued, then *your* surviving *spouse's* death claim will be paid to *your* surviving *spouse's beneficiary*.

For A Dependent Claim
You will receive payment within two (2) months of *our* receipt of the necessary written proof supporting the death claim. Refer to the Life Claim Information section in this certificate for information on the required documentation and process to file a claim. All *dependent* benefits will be paid to *you*. Benefit payments for *your dependent's* life insurance are made in a lump sum.

Assignment

An assignment is the transfer of *your* rights under the group *Policy* to a person *you* name. *You* may assign as a gift, all ownership of *your life insurance benefit*. The following rules apply to assignments:

(1) The Company and *your employer* must give written consent to the assignment. To request assignment of *your* life insurance *you* must complete an assignment form. Forms are available from *your employer* and *us.* Send the completed form to *us* for consent. *You* may wish to contact legal counsel prior to assigning *your* life insurance rights. Neither *your employer* nor the Company guarantees or assumes any obligation concerning the sufficiency or validity of any assignment for purposes of *your* tax or estate planning.
(2) Insurance under any coverage providing periodic benefits on account of disability benefits may be assigned only as a gift assignment.
(3) Insurance under any other coverage providing death benefits may be assigned either as a gift assignment or as a value assignment made in consideration of *terminal illness*.
(4) Insurance under any other coverage may be assigned without restriction. Any rights, benefits or privileges that you have as an *employee* may be assigned. This includes any right you have to choose a *beneficiary* or to convert to another contract of insurance. *We* will not decide if an assignment does what it is intended to do. *We* will not be held to know that one has been made unless it or a copy is filed with *us* through the *Policyholder*.

This provision applies only to insurance for which *you* have the right to choose a *beneficiary*, when that right is assigned. If an assigned amount of insurance becomes payable on account of *your* death and, at *your* death, there is no *beneficiary* chosen by the assignee, it will be payable to:

- the assignee, if living; or
- the estate of the assignee, if the assignee is not living.

It will not be payable as stated in the *beneficiary* rules.

Claims Of Creditors

Life benefit payments are exempt from legal or equitable process for *your* debts, where permitted by *law*. The exemption also applies to the debts of *your beneficiary*.

Benefit Reductions

When Life Amounts Are Reduced

Age Reduction Rules

Life insurance amounts will be reduced at age 65, then continue to decrease according to the age reduction rules in the Benefits Schedule.

Reductions are based on the *amount of life insurance* in force on the day prior to the first of the month in which *you* attain age 65. The reduction will take effect immediately on the date on which *you* attain the limiting age.

Once *your* benefit has been reduced, there will be no further increases in *your* insurance amount even if *your* salary or *eligible class* changes.

You may become eligible for coverage after *you* reach age 65. *Your amount of life insurance* will be figured by multiplying:

- the amount of insurance *you* would have been eligible for prior to age 65; times
- the applicable percentage, based on *your* current age.

Impact On Benefits When You Retire

Life insurance ends when *you* retire.

Life Insurance Coverage When You Become Disabled

Your life insurance coverage may be continued for a specific time if *you* qualify as described below.

Premium Waiver

Your life insurance coverage may be extended for a specific time and *your* life insurance premium will be waived if *we* determine that *you* have become disabled while *you* are insured under this *Plan* and *you* meet the conditions as described below.

How Do We Define A Total Disability?

You are disabled when *we* determine that *you* are not working in any occupation and, due to *your injury* or *sickness*, are unable to perform the duties of any *gainful occupation* for which *you* are reasonably fitted by training, education or experience.

You must be under the *regular care* of a *physician* in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require *you* to be examined by a *physician*, other medical practitioner or vocational expert of *our* choice. *We* will pay for this examination. *We* can require an examination as often as it is reasonable to do so, but not more often than every three (3) months. *We* may also require *you* to be interviewed by *our* authorized representative.

How Long Must You Be Disabled Before You Are Eligible To Have Life Insurance Premiums Waived?

You must be *totally disabled* through *your elimination period*. *Your elimination period* is nine (9) months.

Applying For The Life Insurance Premium Waiver

Ask *your employer* for a life insurance premium waiver claim form. The form has instructions on how to complete and where to send the claim.

You or *your employer* must continue to make life insurance payments for the first nine (9) months following the date *you* become disabled or until *we* determine that *you* are *totally disabled*, whichever occurs first. If *we* then determine that *you* are *totally disabled*, the life insurance coverage *you* had prior to *your* disability will continue. *We* will not require further premium payments for *you* while *you* remain disabled according to the terms and provisions of the *Plan*.

Amount Of Insurance

Your extended *life insurance benefit* under the premium waiver feature will be the *amount of life insurance* that was in force for *you* at the time *your* disability began. This amount may be subject to age reduction rules outlined in this Certificate.

When Your Life Insurance Premium Waiver Begins

Your life insurance premium waiver will begin when *we* approve *your* claim, if the *elimination period* has ended and *you* meet the following conditions. *Your employer* may continue premium payments until *we* notify *your employer* of the date *your* life insurance premium waiver begins.

Your life insurance premium will be waived if *you* meet these conditions:

- *you* are less than 60 years and insured under the *Plan*;
- *you* become disabled and remain disabled during the *elimination period*;
- *you* meet the notice and proof of claim requirements for disability while *your* life insurance is in effect or within three (3) months after it ends; and
- *your* claim is approved by *us.*

After *we* approve *your* claim, *we* do not require further premium payments for *you* while *you* remain disabled according to the terms and provisions of the *Plan.*

Your life insurance amount will not increase while *your* life insurance premiums are being waived.

Your life insurance amount will reduce or cease at any time it would reduce or cease if *you* had not been disabled.

Continued Proof Of Disability

You must furnish evidence of *your* disability when requested by *us*. *We* also have the right to examine *you* at *our* own expense and will use this information to determine if *you* are *totally disabled*, but not more often than every three (3) months.

When Your Life Insurance Premium Waiver Ends

The life insurance premium waiver will automatically end if:

- *you* recover and *you* no longer are disabled;
- *you* are able to work at any *gainful occupation* for pay or profit;
- *you* fail to give *us* proper proof that *you* remain disabled;
- *you* refuse to have an examination by a doctor chosen by *us;*
- *you* reach age 65 or *your* retirement date, whichever occurs first.

You will not be considered retired or reaching *your* retirement date if *you* are receiving disability payments under:

- the United States Social Security Act;
- any similar *law, plan or act*; or
- *your employer's retirement plan*.

However, *you* will be considered retired if *you* are receiving retirement benefits.

Total Disability Extended Benefit

If *your* death occurs within one (1) year after the last day *you* are in *active employment*, and the *Policyholder* continues to pay premiums on *your* behalf, the amount of *your* death benefit will be paid if the following conditions are met:

- *you* became *totally disabled* while insured*;*
- *you* became *totally disabled* before *your* 65th birthday;
- *you* stayed *totally disabled* until *your* death; and
- within one (1) year after *your* death, *your* authorized representative furnishes proof to *us* that *you* met the conditions listed above.

The amount of insurance payable at death will be the same amount for which *you* would have been eligible if *you* were not *totally disabled*, subject to any benefit reduction indicated in this Certificate or any life benefit paid under this *Plan* prior to *your* death.

At any time during the period in which the insurance is extended, *we* may require *you* to provide medical proof of the continuing *total disability*. At *our* expense, *we* may require *you* to submit to an independent exam by a *physician we* choose.

There will be no extension of insurance under the provisions of this section if an individual policy of life insurance is issued to *you* under the conversion privilege, unless the individual policy is surrendered to the Company without claim except for the return of any premium paid.

Coverage extended on any *Insured* under the provisions of this section will automatically terminate:

- when premium payments stop;
- if *you* cease to be *totally disabled*, except that if *you* return to *active employment* in an *eligible class*, *your* insurance will be continued subject to payment of premiums by the *Policyholder*;
- if *you* refuse to submit to any physical examination required by the Company;
- if *you* fail to provide proof of *total disability* in accordance with the terms of this section; or
- the group *Policy* is cancelled.

Upon termination of *your* insurance, *you* will be entitled to the benefits described in the section entitled "Conversion Privilege".

How Do We Define A Total Disability?

You are disabled when *we* determine that, during and beyond the *elimination period*, *you* are unable to perform any of the *material and substantial duties* of your *regular occupation* due to *your injury* or *sickness.*

You must be under the *regular care* of a *physician* in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require *you* to be examined by a *physician*, other medical practitioner or vocational expert of *our* choice. *We* will pay for this examination. *We* can require an examination as often as it is reasonable to do so, but not more often than every three (3) months. *We* may also require *you* to be interviewed by *our* authorized representative.

Life Insurance Limitations And Exclusions

No *life insurance benefit* is payable under this *Policy* if death is caused by, contributed to by or results from:

- suicide, while sane or insane, or from an intentionally self-inflicted *injury*, within two (2) years from the initial effective date of coverage under the *Policy*; and
- suicide, while sane or insane, or from an intentionally self-inflicted *injury*, within two (2) years from the effective date of an increase in coverage under the *Policy.* The death benefit is limited to the amount of coverage in force prior to the increase.

The suicide exclusion applies only to any amounts of insurance for which *you* pay part of the premium.

If benefits are denied under this exclusion, all premiums which have been paid by *you* for the denied benefit or the portion of denied benefit, will be returned to *you* in accordance with the *beneficiary* rules.

Plan Conversion Options

Conversion Insurance Option While You Are Satisfying The Disability Requirements

You may use the life conversion privilege when *your* life insurance terminates while *you* are satisfying the disability requirements. Please refer to the conversion privilege below. *You* are not eligible to apply for the life conversion option if *you* return to work and, again, become covered under the *Plan*.

If an individual conversion life insurance policy is issued to *you* by *us*, any benefit for *your* death under this *Plan* will be paid only if the individual policy is returned for surrender to *us. We* will refund all premiums paid for the individual policy.

The amount of *your* death benefit will be paid to *your* named *beneficiary* for the *Plan*. If, however, *you* named a different *beneficiary* for the individual policy and the policy is returned to the Company for surrender, that different *beneficiary* will not be paid. If *you* want to name a different *beneficiary* for this group *Plan*, *you* must change *your beneficiary* as described in the *beneficiary* designation page of this group *Plan*.

Conversion Policy When Coverage Ends Under This Option

When coverage ends under the *Plan, you and your dependents* may convert *your* group term life coverages to individual life policies, without *evidence of insurability*. The maximum amounts that *you* can convert are the amounts *you and your dependents* are insured for under the *Plan*. *You* may convert a lower *amount of life insurance*.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- *your* employment terminates; or
- *you and your dependents* are no longer are eligible to participate in the coverage of the *Plan*.

If *you* convert to an individual life policy, then return to work, and again, become insured under the *Plan, you* must surrender that individual life policy when *you* return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by the Company or any subsidiaries or affiliates. The person may elect one (1) year of preliminary term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

Optional Conversion Policy When The Group Policy Or The Plan Is Cancelled

You and your dependents may convert a limited *amount of life insurance* if *you* have been insured under *your employer's* group *Plan* with the Company for at least five (5) years and the *Policy* or the *Plan*:

- is cancelled with *us*; or
- changes so that *you* no longer are eligible.

The individual life policy maximum for each of *you* will be the lesser of:

- $10,000; or
- *your and your dependents* coverage amounts under the *Plan* less any amounts that become available under any other group life *Plan* offered by *your employer* within 31 days after the date the *Policy* or the *Plan* is cancelled.

Premiums For Conversion Plans

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- the Company's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

Payable Life Insurance Benefit During The Conversion Period

A term *life insurance benefit* is payable for an *Insured* during the conversion period who dies:

- within 31 days after group coverage under this *Plan* ends; and
- while entitled to convert coverage under this *Plan* to an individual contract.

The amount of the benefit is equal to the *amount of life insurance* benefit, under this *Plan*, the *Insured* was entitled to convert. It is payable even if *you* did not apply for conversion. It is payable when *we* receive written proof of death and *we* approve the claim.

Applying For Conversion Insurance

Ask *your employer* for a conversion application form which includes cost information. When *you* complete the application, send it with the first premium amount to:

Zurich American Life Insurance Company
Conversion Unit
PO Box 7728
Overland Park, Kansas 66207-0728

ACCELERATED DEATH BENEFIT OPTION

The accelerated death benefit option allows *you* to receive a one time partial *life insurance benefit* if, while covered under the *Plan*, *you or your spouse* or domestic partner are diagnosed with a *terminal illness* and not expected to survive more than 12 months. The accelerated death benefit is subject to the terms and conditions of the *Policy*.

This benefit option does not apply to any *terminal illness* resulting from an intentionally self-inflicted *injury* or suicide attempt.

You may request and receive an accelerated death benefit under this *Plan* only once on *your* own behalf and only once on behalf of *your dependent*.

The amount of the accelerated death benefit available is a percentage of the amount of *employee* term life insurance that *you* elected under the *Plan*. *You or your spouse* or domestic partner may request up to 80% of the term life insurance that is currently in effect for *you* or the person for whom *you* are making the request on the date *we* receive proof that *you or your spouse* or domestic partner are *terminally ill*. But the amount *you* request may not be:

- less than the accelerated death benefit minimum; or
- more than the accelerated death benefit maximum.

Refer to the Benefits Schedule for specific amounts.

The benefit may be reduced if, within six (6) months after the date *we* receive such proof, a reduction on account of age would have applied to the amount of *your employee* term life insurance. In that case, the amount of the benefit payable may not exceed the amount of the term life insurance after applying the reduction.

The *amount of life insurance* after the accelerated death benefit has been paid will remain in force and be paid in accordance with the terms of the Certificate describing *your* coverage, subject to the terms and conditions of the *Policy.*

Tax Consequences

The accelerated death benefit under this certificate may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as *your* life expectancy at the time benefits are accelerated or whether *you* use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the accelerated death benefit qualifies for favorable tax treatment, the benefits will be excludable from *your* income and not subject to federal taxation.

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

Receipt of accelerated benefit may affect *your*, *your spouse* or *your* family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect *you*, *your spouse* and *your* family's eligibility for public assistance.

Electing The Accelerated Death Benefit Option

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

- *you or your spouse* or domestic partner must be *terminally ill* at the time of payment of the accelerated death benefit;
- *your employee* term life insurance must not be assigned (please see the Assignment Section below);
- *our* claims handling rules apply to the payment of benefits under this option;
- *you* or *your spouse* or domestic partner must request the accelerated death benefit election in writing on a form acceptable by *us* and submit the request form to *us*; and
- *you* must also provide *us* the following:

    1) A *physician's* certification that *you or your spouse* or domestic partner are suffering from a non-correctable *terminal illness* and *your or your spouse's* or domestic partner's *life expectancy* has been reduced to less than 12 months. The *physician's* certification must be deemed satisfactory to *us.*

    2) A copy of:

        - all medical test results;
        - laboratory reports; and
        - all supporting documentation and information on which the *physician's* statement is based.

We may, at *our* own expense, require *you or your spouse* or domestic partner to submit to an independent medical exam by a *physician we* choose and as often as *we* deem reasonably necessary to determine the validity of *your* claim. *We* reserve the right to rely on the *physician we* choose for purposes of validating *your* benefit request. *We* will not process *your* accelerated death benefit request until the exam has been completed and *we* have received the results.

We May Refuse Your Election Request

We may stop processing *your* request or refuse *your* request if:

- the group *Policy* terminates coverage for *your eligible class* before *we* approve *your* request (even if all or part of *your* life insurance coverage continues for any reason);
- all of *your* life insurance coverage terminates under the group *Policy* for any reason before *we* approve *your* request; or
- *you* or *your spouse* or domestic partner die before *we* issue the accelerated death payment.

Assignment

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

Accelerated Death Benefit Payment

If *your* request is approved, *we* will pay *you* the accelerated death benefit in a lump sum. Benefits are payable to *you*.

Premium Payments

Premium payments must continue to be paid on the full *amount of life insurance* unless *you* qualify to have *your* life premium waived.

Also, premium payments must continue to be paid on the full amount of *your dependent's* life insurance unless *you* qualify to have *your* life premium waived.

Effect Of An Accelerated Death Benefit Payment On Your Plan

This benefit is in lieu of the benefits that would have been paid on *your or your spouse's* or domestic partner's death. Accordingly, an election to receive an accelerated death benefit will have the following effect on other benefits:

Your Life Insurance Benefit
The *amount of life insurance* covering *you or your spouse* or domestic partner including any amount under an extended death benefit, will be reduced by the amount of any accelerated death benefit payment.

Life Continuation And Conversion
Any *amount of life insurance* that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the accelerated death benefit payment. The converted amount will be limited to the reduced *amount of life insurance* remaining after the benefit payment subject to any reduction and termination provisions.

Refer to conversion for more information about the conversion privilege.

Extended Benefits Under The Permanent And Total Disability Feature

You may apply for an accelerated death benefit payment if *you* have qualified for an extension of *your* life insurance because of *your* permanent and total disability, as long as *you* have not previously requested an accelerated death benefit payment. All of the terms of the accelerated death benefit feature will apply to an accelerated death benefit request *you* make while *your* life insurance is being extended under the terms of the permanent and total disability provision.

For more information about the permanent and total disability provision, refer to permanent and total disability.

Claims Of Creditors

To the extent allowed by *law*, *you* are not required to request an accelerated death benefit in order to satisfy claims of creditors.

ADDITIONAL BENEFIT FEATURES

Continuity Of Coverage

Effect Of Prior Coverage - Transferred Business

(Continuity of Coverage when *you* are not in *active employment* when the *Policyholder* changes insurance carriers to *us*.)

If *your* coverage under any part of this *Plan* replaces any prior coverage that *you* had, the following rules apply:

"Prior coverage" means any *plan* of group coverage sponsored by *your employer* that has been replaced by coverage under all or part of this *Plan* (e.g. transferred business). The replacement coverage under the new *Plan* may be for all or part for the *eligible class* to which *you* belong. Any such *plan* is prior coverage if provided by another group policy or any benefit section of this *Plan*.

When this *Plan* becomes effective, *we* will provide group life insurance coverage for *you* as long as *you* are not receiving benefit payments for extended life disability benefits (e.g. waiver of premium, extended death benefit or permanent total disability) under the prior carrier's *plan*; and

- *you* are not in *active employment* because of a *sickness* or *injury*;
- *you* were covered by the prior carrier's *plan* on its termination date; and
- *your* name is shown on the listing, that has been approved by *us* and the *Policyholder*, contained in *our* file.

We will also provide group *dependent* life insurance coverage for *your dependent* if:

- *your dependent* is *totally disabled*; and
- *your dependent* was covered by the prior carrier's *plan* on its termination date; and
- *your dependent's* name is shown on the listing that has been approved by *us*, contained in *our* file.

Premium Payments

Premium payments are required for *you* during the period this coverage continues in force. In effect, *we* will not waive premium during the period continuity of coverage continues.

Coverage provided under this continuity of coverage provision will automatically end on the date *you* return to *active employment*, on the date *you* recover and no longer are disabled or on the date this group *Policy* or a *Plan* is cancelled.

Discontinuance And Replacement

In addition, the amounts of insurance *you* elect are subject to the provisions of the prior carrier's *plan*. Any and all exclusions, reductions, limitations, and/or specific termination dates or provisions of the prior carrier's *plan* will apply.

In addition, the "Portability" provision under this Certificate will not apply.

Portability (Class 1 and Class 2)

(Available coverage if *you* end employment or work reduced hours.)

Your life insurance may be continued if *your* coverage under the group life insurance *Policy* ends because:

- *your* employment ends with or *you* retire from *your employer*;
- *you* are no longer in an *eligible class*; or
- *your dependents* lose coverage when they no longer qualify as a covered d*ependents*.

In case of *your* death, *your* insured *dependents* also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the *spouse* also becomes insured for portable coverage.

All of the terms and conditions of *your* group term life insurance will apply under the portability provision except as described below.

Conversion Privilege

The life insurance conversion provision does not apply to any amount of *your* life insurance for which *you* elect coverage under this provision. It may be available for:

- any amount of *your* life insurance to which the terms of this portability provision do not apply;
- any amount of *your* life insurance to which the terms of this portability provision apply, but for which *you* do not elect coverage under this provision; or
- any amount of *your* life insurance in force under this portability provision that stops because of age.

Portable Insurance Coverage And Amounts Available

The portable insurance coverage will be the current coverage and amounts that *you* are insured for under *your employer's* group *Plan*.

However, the amount of portable coverage for *you* will not be more than:

- the highest *amount of life insurance* available for *employees* under the *Plan*; or
- 5 x *your annual earnings*; or
- $2,000,000 from all *our* group life *Plans* combined, whichever is less.

The amount of portable coverage for *your spouse* will not be more than:

- the highest *amount of life insurance* available for *spouses* under the *employer's* group supplemental *Plan;* or
- 50% of *your* amount of portable coverage; or
- $500,000 from all *our* group life *Plans* combined, whichever is less.

The amount of portable coverage for a child will not be more than:

- the highest *amount of life insurance* available for children under the *Plan*; or
- 50% of *your* amount of portable coverage; or
- $25,000 whichever is less.

The minimum amount of coverage of life insurance that can be ported is:

- $10,000 for *you*; and
- $1,000 for *your dependents*.

If the current amounts under the group life *Plan* are less than $10,000 for *you* and $1,000 for *your dependents, you* may not port the lesser amounts.

Portable coverage will reduce at the ages and amounts shown in the life insurance Benefits Schedule.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for *your eligible class* if *you* had continued in *active employment* with *your employer*.

If *your employer* terminates the group *Plan* following *your* election of portable insurance coverage, *your* portable coverage may be continued subject to the terms of this Certificate.

Applying For Portable Coverage

You must submit a written request and pay premium within 31 days after *your* insurance coverage under the *employer's* group *Plan* ends.

To do so *you* must:

- obtain and complete a portability request form and submit it to *us;*
- submit *evidence of insurability* if *you* are applying for more than the maximum that can be applied for without *evidence of insurability*; and
- submit the first premiums for the amounts not requiring *evidence of insurability* due with the completed request form to *us*.

In the event of *your* death, *your dependents* must apply for portable coverage and pay the first premium within 31 days after the date *you* die.

You are not eligible to apply for portable coverage for yourself if:

- *you* are ill or *injured* and away from work on the date *your* coverage stops under this *Plan;*
- coverage under the group *Policy* is canceled and replaced by like coverage under another policy;
- coverage under the group *Policy* is canceled because *your employer* has gone out of business;
- *you* have an *injury* or *sickness* under the terms of this *Plan*, which has a material effect on life expectancy;
- coverage has been converted to an individual life policy in accordance with the *Plan's* conversion privilege;
- *you* are older than age 69; or
- *you* failed to pay the required premium under the terms of this *Plan*.

You are not eligible to apply for portable coverage for a *dependent* if:

- *you* do not elect portable coverage for yourself;
- *your dependent* child has less than 12 months to reach the age where he or she will not meet the *Plan's* definition of a *dependent* child;
- *your dependent spouse* is older than age 69;
- *you* have an *injury or sickness* under the terms of this *Plan,* which has a material effect on life expectancy;
- *your dependent* has an *injury* or *sickness* under the terms of this *Plan*, which has a material effect on life expectancy; or
- *you* failed to pay the required premium under the terms of this *Plan.*

In case of *your* death, *your spouse* is not eligible to apply for portable coverage if:

- *your* surviving *spouse* is not insured under this *Plan*;
- *your* surviving *spouse* has an *injury* or *sickness* under the terms of this *Plan*, which has a material effect on life expectancy; or
- *you* failed to pay the required premium under the terms of this *Plan* for *your spouse*.

In case of *your* death, *your* child is not eligible to apply for portable coverage if:

- *your* surviving *spouse* is not insured under this *Plan*;
- *your* surviving *spouse* is insured under this *Plan* and chooses not to elect portable coverage;
- *your* surviving *spouse* has an *injury* or *sickness*, under the terms of this *Plan* which has a material effect on life expectancy;
- *your dependent* child has less than 12 months to reach the age where he or she will not meet the *Plan's* definition of a *dependent* child;
- *your* child has an *injury* or *sickness*, under the terms of this *Plan*, which has a material effect on life expectancy; or
- *you* failed to pay the required premium under the terms of this *Plan* for *your* child.

If *we* determine that because of an *injury* or *sickness*, which has a material effect on life expectancy, *you* were not eligible for life insurance portability at the time *you* elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the *Plan's* conversion privilege.

Portability Effective Date

Life insurance coverage, which does not require *evidence of insurability* under this provision, will become effective at the end of the 31 day election period if *you* have completed a portability request form and submitted the first premium.

Insurance coverage which requires *evidence of insurability* under this portability provision will become effective on the date *we* approve *your evidence of insurability*. *You* are required to submit premium for the *amount of life insurance* requiring *evidence of insurability* within 31 days of *our* approval.

Your effective date of coverage under the portability feature is called *your* portability date.

Applying For Increases Or Decreases In Portable Coverage

You may increase or decrease the *amount of life insurance* coverage. The minimum and maximum benefit amounts are shown above. However, the *amount of life insurance* coverage cannot be decreased below $10,000 for *you* and $1,000 for *your dependents*.

All life insurance increases are subject to *evidence of insurability*. If *evidence of insurability* for *you* is approved by *us, you* will be billed separately for the amount of the coverage requiring evidence approval. If *you* die prior to sending *us* premium for amounts requiring *evidence of insurability* the benefit payment will be limited to the amount for which premium has been paid.

Any premium that *we* collected for amounts above which *evidence of insurability* is required will be refunded if *we* do not approve *your evidence of insurability*. The coverage amount that *we* approve will take effect on *your* portability effective date.

Coverage amounts that are not approved may be converted to an individual policy in accordance with this *Plan's* conversion of life insurance provision.

When Portable Coverage Ends

Portable coverage for *you* will end on the date:

- *you* fail to pay any required premium;
- the date of *your* death; or
- the first anniversary of *your* portability effective date following the date *you* reach age 70.

Portable coverage for a *spouse* will end for the following reasons:

- the date *you* fail to pay any required premium;
- the date *your* surviving *spouse* fails to pay any required premium;
- the date of *your* death;
- the date *your spouse* no longer qualifies as a defined *dependent*; or
- the first anniversary of his or her portability date following the date *your spouse* reaches age 70.

Portable coverage for a child will end for the following reasons:

- the date *you* fail to pay any required premium;
- the date *your* surviving *spouse* fails to pay any required premium;
- the date *your* child no longer qualifies as a *dependent*;
- the date the surviving *spouse* dies;
- the date of *your* death.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

Premium And Billing Charges

Premium Payments

Premium payments are required for *you and your dependents* during the period this portability coverage continues in force. Premiums for coverage under this provision will be paid directly to *us*.

The premium will include a fee for the direct billing services *we* provide. The fee for direct billing may change, but not more than once a year.

The premium rate for non-contributory coverage in force under this provision will be set on *your* portability date. Any premium collected for amounts above which *evidence of insurability* is required will be refunded if *we* do not approve *your evidence of insurability*.

Premium Rate Changes

We may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all *Insureds*;
- changes occur in other risk factors; or
- a new *law* or a change in any existing *law* is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to *our* underwriting risk studies. *We* will notify the *Insured* in writing at least 31 days before a premium rate is changed.

Accelerated Death Benefit

The accelerated death benefit provision, if included in the life *Plan*, does not apply to life insurance in force under this portability provision.

Applying For A Life Conversion Policy If Portable Coverage Ends Or Is Not Available

If *you* and *your dependents* are not eligible to apply for portable coverage or portable coverage ends, then *you* and *your dependents* may qualify for conversion coverage. Refer to conversion privilege under this *Plan.*

Ask *your employer* for a conversion application form which includes cost information.

When *you* complete the application, send it with the first premium amount to:

Zurich American Life Insurance Company
Conversion Unit
PO Box 7728
Overland Park, Kansas 66207-0728

CLAIM INFORMATION

Zurich American Life Insurance Company
Term Life Insurance

Reporting Of Claims

We encourage *you* or *your* authorized representative to notify *us* as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on *your* disability, telephonic notice, as authorized by *us* or written notice and proof of claim must be provided no later than 90 days after the end of the e*limination period*.

If a claim is based on death, telephonic notice as authorized by *us* or written notice and proof of claim must be provided no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than one (1) year after the time proof is required as specified above. These time limits will not apply during any period *you* or *your* authorized representative lacks the legal capacity to give *us* proof of claim.

If *you* choose to file a written notice of claim, the claim form is available from *your employer,* or *you* or *your* authorized representative can request a claim form from *us*. If *you* or *your* authorized representative does not receive the form from *us* within 15 days of *your* request, send *us* written proof of claim without waiting for the form.

If *you* submit a claim before *you* have been notified of *our* decision on any coverage amount requiring *evidence of insurability*, *your* amount of coverage will be determined as if *our* final underwriting decision had been made prior to the date of claim.

If *you* have a disability, *you* must notify *us* immediately when *you* return to work in any capacity, regardless of whether *you* are working for *your employer*.

Filing A Claim For A Disability

You may file proof of claim by telephonic means. Contact *your employer* for more information on how to file *your* claim by telephone. *You* will be required to sign an authorization form in order for *us* to obtain medical information from *your* attending *physician*. If *we* are unable to obtain *your* medical information, *we* will send a letter and appropriate forms to *you* for completion to be returned to *us* by the date determined in the letter.

If *you* choose to file written notice of claim, *you* or *your* authorized representative and *your employer* must complete *your* own sections of the claim form and then give it to *your* attending *physician*. *Your physician* should complete his or her section of the form and send it directly to *us*.

Information Required For Proof Of Your Disability Claim

If the claim is based on *your* disability, proof of claim, provided at *your* expense, must show:

- that *you* are under the *regular care* of a *physician*;
- the appropriate documentation of *your annual earnings*;

- the date *your* disability began;
- the cause of *your* disability;
- the extent of *your* disability, including restrictions and limitations preventing *you* from performing *your regular occupation* or any *gainful occupation*; and
- the name and address of any *hospital* or *institution* where *you* received treatment, including all attending *physicians*.

We may request that *you* send proof of continuing disability indicating that *you* are under the *regular care* of a *physician*. This proof, provided at *your* expense, must be received within 30 days of a request by *us*.

In some cases, *you* will be required to give *us* authorization to obtain additional medical and non-medical information as part of *your* proof of claim or proof of continuing disability. *We* may not be able to process *your* claim if the appropriate information is not submitted. *We* may deny *your* claim or terminate *your* payments until *we* receive the required information.

Information Required For Proof Of Death

A certified copy of the death certificate must be given to *us* with proof the claimant is entitled to the insurance proceeds. Proof of claim for death must show the cause of death and be provided at *your* or *your* authorized representative's expense. *We* may not be able to process *your* claim if the appropriate information is not submitted. *We* may deny *your* claim until *we* receive the required information.

Claim Notification

We will notify a claimant in writing of the acceptance or rejection of a claim no later than the 15th business day after the date *we* receive all items, statements, and forms required by *us* to secure final proof of loss.

If *we* are unable to accept or reject the claim, *we* will notify the claimant of the reasons that *we* need additional time within 15 business days of *our* receipt of the claim information. *We* will accept or reject the claim within 45 days after the date of this notice.

If *we* reject the claim, the notice *we* will state the reasons for the rejection.

Death Claim Payment

We will settle a death claim within two (2) months following *our* receipt of satisfactory proof of loss as described above. *We* will pay interest on the proceeds from the date *we* receive satisfactory proof of loss until the date *we* approve the claim. The interest rate will be the rate at which interest accrues on proceeds that are left on deposit with the Company.

When Can We Request An Autopsy?

In case of death, *we* will have the right and opportunity to request an autopsy where not forbidden by *law*.

What Happens If We Overpay Your Claim?

We have the right to recover any overpayments due to fraud or *our* error. *You*, *your* authorized representative or *your beneficiary* must reimburse *us* in full. *We* will not recover more money than the amount *we* paid *you*. *We* will determine the method by which the repayment will be made.

We have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law,* in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

Unpaid Premium Due

Any unpaid premium due for *your* coverage under this *Policy* may be recovered by *us* by offsetting against amounts otherwise payable to *you*, *your beneficiary* or *your* legal representative under this *Policy,* or by other legally permitted means.

What Are The Time Limits For Legal Proceedings?

You can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to three (3) years from the time proof of claim is required, unless otherwise provided under federal *law*.

GLOSSARY

General definitions used throughout this Certificate include:

Actively at Work, Active at Work or Actively Working means at work with *your employer* on a day that is one of *your employer's* scheduled workdays. On that day, *you* must be performing for wage or profit, all of the regular duties of *your* job in the usual way, and for *your* usual number of hours.

Active Employment means *you* are working for *your employer* for earnings that are paid regularly and that *you* are performing the *material and substantial duties* of *your regular occupation*. *You* must be working at least the minimum number of hours as described under eligible group(s) in each *Plan.*

Your work site must be:

- *your employer's* usual place of business;
- an alternative work site at the direction of *your employer*; or
- a location to which *your* job requires *you* to travel.

Normal vacation or a holiday is considered *active employment*. Temporary and seasonal workers are excluded from coverage.

Administrator means Zurich American Life Insurance Company.

Amount of Life Insurance means both the Basic and Supplemental Life Amounts unless otherwise stated in specific provisions and benefits.

Annual Earnings means *your* gross annual income from *your employer* in effect just prior to the date of loss. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation, section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from services other than *your employer*.

For purposes of calculating benefits payable to *you*, *annual earnings* means *your* actual earnings as defined above, as of the date *your employer* most recently reported *your* earnings to *us* prior to *your* date of loss. Check with *your employer* to determine the amount of earnings it reports to *us* for *you* and how frequently earnings are reported.

Appropriate Care means the determination of an accurate and medically supported diagnosis of the *Insured's* disability, or ongoing medical treatment and care of the *Insured's* disability by a *physician* that conforms to generally-accepted medical standards, including frequency of treatment and care.

Confined or Confinement means a *hospital* stay of at least eight (8) hours per day.

Dependent means *your spouse*, domestic partner, and *dependent* children. A *dependent* must be a citizen or legal resident of the United States, its territories and protectorates. Any person who is in full-time military service cannot be a *dependent*.

Eligible Class(es) means the classes of *employees* that *your employer* has selected as being eligible to receive coverage under a *Plan*. *Your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions established by *your employer*.

Eligible Survivor means *your spouse*, if living, otherwise *your* children under age 26 equally.

Eligibility Date means the date *you* become eligible for insurance.

Elimination Period means a period of continuous disability which must be satisfied before *you* are eligible to have *your* life premium waived by *us* or receive a permanent disability benefit.

Employee means a person who is in *active employment* working and residing inside of the United States with the *Policyholder* and the *employees*, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the *Policyholder* and such affiliated corporations, proprietorships or partnerships is under common control. *Employee* shall exclude in any case, temporary *employees* and *employees* who work for the *employer* less than the number of hours per week indicated in the Benefits Schedule. This term does not include *employees* who normally work less than 30 hours a week for the *Policyholder*.

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

Evidence of Insurability means a statement of *your* or *your dependent's* medical history which *we* will use to determine if *you or your dependents* are approved for coverage. *Evidence of insurability* will be at y*our* expense.

Full-Time as used for an *Insured* means the number of hours set by the *Policyholder* as a regular work day for *full-time employees* in the *Insured's eligible class*.

Gainful Occupation/Gainful Employment means an occupation that within 12 months of *your* return to work is or can be expected to provide *you* with an income that is at least equal to 60% of *your annual earnings* in effect just prior to the date *your* disability began.

Grace Period means the period of time following the premium due date during which premium payment may be made.

Home Office means 1299 Zurich Way, Schaumburg, IL 60196.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing *your* disability.

Illness means a pathological condition of the body that presents a group of clinical signs and symptoms and lab findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury means:

- for purposes of portability, a bodily *injury* that is the direct result of an *accident* and not related to any other cause;
- for all other purposes, a bodily *injury* that is the sole and direct result of an *accident* and not related to any other cause. Disability must begin while *you* are covered under the *Plan.*

Insured means any person covered under a *Plan* for which premium has been paid.

Late Applicant means *you* apply for coverage for yourself more than 31 days after the date *you* or *your dependents* are eligible for coverage.

Law, Plan or Act means the original enactments of the *law*, *plan* or *act* and any amendments.

Layoff or **Leave of Absence** means *you* are temporarily absent from *active employment* for a period of time that has been agreed to in advance in writing by *your employer*.

Your normal vacation time or any period of disability is not considered a temporary *layoff* or *leave of absence*.

Life Insurance Benefit means the total benefit amount for which an *employee* is insured under this *Plan* subject to the maximum benefit.

Life Status Change means a change in status as defined in the regulations under Internal Revenue Code Section 125, unless *your employer's* cafeteria *Plan* document or human resource policy contains more restrictive provisions. In that event, *your employer* may restrict the situations where *you* can change *your* coverage.

Life Threatening Condition is a critical health condition that may possibly result in *your or your dependent spouse's* loss of life.

Material and Substantial Duties means duties that normally are required for the performance of *your* regular occupation, and cannot be reasonably omitted or modified.

Maximum Period of Payment means the longest period of time *we* will make payments to *you* for any one period of disability.

Normal Retirement Age means the Social Security *normal retirement age* as stated in the 1983 revision of the United States Social Security Act. It is determined by *your* date of birth.

Payable Claim means a claim for which *we* are liable under the terms of the *Policy.*

Physician means:

- a person performing tasks that are within the limits of his or her medical license; and a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the *laws* and regulations of the governing jurisdiction.

We will not recognize *you*, or *your spouse*, children, parents or siblings as a *physician* for a claim that *you* send to *us.*

Plan means a line of coverage under the *Policy.*

Policy means the *Policy* provided to the *employer.*

Policyholder means the *employer* to whom the *Policy* is issued.

Prior Plan means a group term life insurance plan sponsored by the *Policyholder* which was in force on the day before the *Policy* effective date of this *Plan.*

Regular Care means:

- *you* personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat *your* disabling condition(s); and
- *you* are receiving appropriate treatment and care of *your* disabling condition(s) by a doctor whose specialty or experience is appropriate for *your* disabling condition(s).

Regular Occupation means the occupation *you* are routinely performing when *your* disability begins.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to *employees* and are not funded entirely by post tax or *employee* contributions, as that term is used in the Internal Revenue Code of 1986, as amended.

Service Waiting Period means the continuous period of time that *you* must be in *active employment* in an *eligible class* before *you* are eligible for coverage under a *Plan*. The *employer* and *we* must agree upon the period.

Sickness means:

- For purposes of portability, an *illness*, disease, or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- For all other purposes, an *illness* or disease. Disability must begin while *you* are covered under the *Plan.*

Spouse means the *Insured's* lawful *spouse*.

Supplement Plan means the option to purchase additional insurance beyond the basic plan. This insurance is elected and paid for by the *Insured*.

Terminally Ill, Terminal Illness means an *illness* or physical condition, including a physical *injury* that can reasonably be expected to result in death in two (2) years or less.

We, **Us** and **Our** mean Zurich American Life Insurance Company, and in connection with the making of all benefit determinations under the *Plan* means Zurich American Life Insurance Company, acting directly or through their agents and delegates.

You, Your means an insured *employee* who is eligible for *our* coverage under this *Plan*.