
**VOLUNTARY GROUP ACCIDENTAL
DEATH AND DISMEMBERMENT
INSURANCE PROGRAM**

Aurora University

CERTIFICATE OF INSURANCE

POLICYHOLDER: Aurora University


GROUP POLICY NUMBER: VAR 203404

POLICY EFFECTIVE DATE: January 1, 2006

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined and your completed Enrollment Card is attached. The Group Policy Number, Policyholder, and Policy Effective Date are listed above.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all Certificates that may have been issued to you earlier.

This Certificate is signed by our President and Secretary.



SECRETARY



PRESIDENT

GROUP ACCIDENT CERTIFICATE

LRS-8605-001-0790

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SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Full-time Employee, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The first of the Policy month coinciding with or next following the day you become eligible.

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE: PRINCIPAL SUM:

INSURED PERSONS:

\$10,000 to \$500,000 in increments of \$10,000, subject to ten times Earnings for amounts over \$150,000.

INSURED DEPENDENTS:

Spouse with no Dependent Child(ren) covered:	50% of your Principal Sum
Spouse with Dependent Child(ren) covered:	40% of your Principal Sum
Each Dependent Child:	10% of your Principal Sum
Each Dependent Child (if no Spouse):	15% of your Principal Sum

The Amount of Principal Sum will be:

- (1) reduced by 35% at age 65; and
- (2) further reduced by 20% of the pre-age 65 amount at age 70; and
- (3) further reduced by 20% of the pre-age 65 amount at age 75.

CHANGES IN AMOUNT OF INSURANCE: Changes in the Amount of Insurance because of a change in age, class or Earnings (if applicable) are effective on the date of the change, provided that if you are not Actively at Work on the date an increase would otherwise take effect for you or your Dependent, such increase will not take effect until the date you return to active work.

Changes in the Amount of Insurance because of your elections will take effect on the date we receive the election request, provided that if you are not Actively at Work on the date an increase is to take effect, such increase will take effect on the date you return to work.

CONTRIBUTIONS: You are required to contribute toward the cost of your insurance coverage. You are required to contribute toward the cost of the Dependent insurance coverage.

DEFINITIONS

"Actively at Work" and "Active Work" means you are actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of Injury or illness.

When an unmarried Insured Dependent reaches the maximum age, coverage will not cease while this insurance coverage remains in force for the Insured Person if: (a) the child is unable to provide self-support due to mental retardation or physical handicap; and (b) he is chiefly dependent on the Insured Person for support; and (c) proof of the above conditions is received as set forth under the section entitled, TERMINATION OF DEPENDENT INSURANCE.

A child who is in your custody, pursuant to an interim court order of adoption vesting temporary care of the child in you, will be considered to be an adopted child, regardless of whether a final order granting adoption is ultimately issued.

NOTE: An Eligible Person may not have coverage both as an Insured Person and as an Insured Dependent. Only one Insured spouse may cover the eligible children as Insured Dependents. If insurance is in force for an Insured Dependent, any newly eligible Dependents will be automatically covered.

"Earnings" means the basic annual wages received from the Policyholder on the day just before the date of the Injury, prior to any deductions to a 401(k) or Section 125 plan. Earnings do not include commissions, overtime pay, bonuses or any other special compensation not received as basic wages.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual Earnings.

"Eligible Person" means a person who meets the Eligibility requirements of the Policy.

"Full-time" means working for the Policyholder for a minimum of 32 hours during a person's regularly scheduled work week.

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

"Insured Dependent" means a "Dependent", as defined, whose insurance under the Policy is in effect.

"Insured" means either an Insured Person or an Insured Dependent unless the context indicates otherwise.

"Injury" means accidental bodily injury to an Insured which is caused directly by accidental means and which occurs while the Insured's coverage under the Policy is in force.

"Policyholder", shall also include an associated or affiliated company, when referring to premium payments; Active Work; Full-time work; or Earnings.

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means the Insured Person.

GENERAL PROVISIONS

CHANGES: No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

INCONTESTABILITY: Any statements made by the Policyholder, any Insured Person, or any Insured Dependent, or on behalf of any Insured Person or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
 - (a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and
 - (b) a copy of such written instrument is or has been furnished to you or any Insured Dependent, or your or any Insured Dependent's beneficiary or legal representative.
- (2) If the statement relates to your or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during your or any Insured Dependent's lifetime.

ASSIGNMENT: Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, us or the Plan Administrator:

- (1) will not terminate insurance that would otherwise have been effective; and
- (2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

MISSTATEMENT OF AGE: If an Insured's age has been misstated, benefits will be those that apply to his correct age.

NOT IN LIEU OF WORKER'S COMPENSATION: The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

PRONOUNS: All pronouns include either gender unless the context indicates otherwise.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the later of:

- (1) the Individual Effective Date as shown on the Schedule of Benefits; or
- (2) on the first day of the month coincident with or next following the date you apply.

If you are not Actively At Work on the day your insurance is to go into effect, your insurance will go into effect on the day you return to Active Work for one full day.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

TERMINATION OF INDIVIDUAL INSURANCE: Your coverage will terminate on the first of the following to occur:

- (1) the date the Policy terminates; or
- (2) the last day of the Policy month in which you cease to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for your coverage.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.

CONTINUATION OF INDIVIDUAL INSURANCE: Your coverage may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

- (1) 12 months, if you cease to be eligible due to illness or Injury; or
- (2) 1 month, if you cease to be eligible due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: If your coverage is terminated, it may be reinstated if you are:

- (1) on an approved leave of absence; or
- (2) on temporary lay-off.

You must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits (INDIVIDUAL REINSTATEMENT). You must also be a member of a class eligible for this insurance.

Unless you are returning after having resigned or having been discharged, you will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the date you return to Active Work.

DEPENDENT INSURANCE

ELIGIBILITY: You are eligible to enroll your eligible Dependents on the date you become an Insured Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE: You may insure your Dependents by making written application. In this case, your Dependent insurance will take effect on the first day of the month coincident with or next following the later of:

- (1) the date you first become eligible for Dependent insurance if application is made on or before that date; or
- (2) the date the dependent meets the definition of Dependent, if application is made on or before that date; or
- (3) the date of enrollment.

After this insurance is in force for one Dependent, application is not required for added Dependents.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

- (1) the date this Section terminates;
- (2) the end of the period for which premium for Dependent insurance has been paid;
- (3) the date your insurance terminates; or
- (4) the date the dependent is no longer a Dependent as defined. However, coverage for an Insured Dependent child which would otherwise cease when such child attains the maximum age, will not cease while your insurance coverage remains in force if:
 - (a) the child is unable to provide self-support due to mental retardation or physical handicap; and
 - (b) he is chiefly dependent on you for support

We will inquire of you 2 months prior to attainment by an Insured

Dependent child of the maximum age or at any reasonable time thereafter, whether such Insured Dependent child meets the conditions set forth above. In the absence of proof submitted within 31 days of such inquiry, coverage will terminate for such Dependent at or after the attainment of the limiting age. In the absence of our request, insurance coverage for such Insured Dependent child will continue as long as:

- (a) your coverage remains in effect;
- (b) the Insured Dependent child remains in the same condition;
and
- (c) the proper premium is paid.

We may ask from time to time if the Insured Dependent child remains a disabled and dependent person. After the 2 year period that follows such Dependent's attainment of the maximum age, this request may not be made more often than once a year.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.

NEWLYWED PROVISION: If you marry and had not previously elected Dependent coverage, your new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

- (1) you request, in writing and within such 31 day period, continuation of such Dependent coverage; and
- (2) the additional premium is paid for such coverage.

In the event that the Insured Person's new spouse suffers a covered loss during the 31 day period during which he may request coverage, and written election has not been made (or, if made, has not been received and processed by the Policyholder), we will pay benefits based upon the minimum principal sum available for that spouse.

NEWBORN CHILDREN: If a child is born to you, and you had not elected Dependent coverage, such child shall be an Insured Dependent from the moment of birth.

The newborn child shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

- (1) you request, in writing and within such 31 day period, continuation of such Dependent coverage; and
- (2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive, foster or step children, as of the date they become financially dependent on you for support, provided they otherwise meet the definition of Dependent.

CONVERSION PRIVILEGE

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy. Insured Dependents can use this Conversion Privilege if they cease to be eligible for any reason other than termination of the group Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

- (1) the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;
- (2) proof of health will not be required; and
- (3) the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

- (1) the Amount of Principal Sum applicable to the Insured under the Policy; or
- (2) \$250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Certificate.

If you have not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:.

- (1) the Insured's legal spouse;
- (2) the Insured's surviving children (including legally adopted children), in equal shares;
- (3) the Insured's surviving parents, in equal shares;
- (4) the Insured's surviving siblings, in equal shares; or, if none of the above,
- (5) the Insured's estate.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the

beneficiary. Payment to a minor shall not exceed \$1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

The balance of the benefit, if any, will be held by us, until an individual or representative:

- (1) is validly named; or
- (2) is appointed to receive the proceeds; and
- (3) can give valid release to us.

We will not be liable for any payment we have made in good faith.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

TIME PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

LEGAL ACTION: No lawsuit or action in equity can be brought to recover on the Policy:

- (1) before 60 days following the date written proof of loss was furnished to us; or
- (2) after 3 years following the date written proof of loss is required (6 years in South Carolina and 5 years in Kansas).

SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, you must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under \$2,000 or option payments of less than \$20 each are not allowed.

If no instructions for a settlement option are in effect at the death of an Insured, the beneficiary may make the election, with our consent.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the 3 set out in the Policy may be made. A mutual agreement must be reached between the individual entitled to elect and us.

OPTION A - FIXED TIME PAYMENT OPTION: Equal monthly payments will be made for any period chosen, up to 30 years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change the minimum monthly payment. These changes will apply only to requests for settlement elected after the change.

Option A Table
Minimum Monthly Payment Rates for each \$1,000 Applied

<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>	
1	\$84.47	7	\$13.16	13	\$7.71	19	\$5.73	25	\$4.71
2	42.86	8	11.68	14	7.26	20	5.51	26	4.59
3	28.99	9	10.53	15	6.87	21	5.32	27	4.47
4	22.06	10	9.61	16	6.53	22	5.15	28	4.37
5	17.91	11	8.86	17	6.23	23	4.99	29	4.27
6	15.14	12	8.24	18	5.96	24	4.84	30	4.18

OPTION B - FIXED AMOUNT PAYMENT OPTION: Each payment will be for an agreed fixed amount. The amount of each payment will not be less than \$20 for each \$2000 applied. Interest will be credited and added each month on the unpaid balance. This interest will be at a rate set by us, but not less than the equivalent of 3% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C - INTEREST PAYMENT OPTION: We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 3% per year.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DESCRIPTION OF COVERAGE

LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING: If, due to Injury, an Insured suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below.

LOSS

BENEFIT AMOUNT:

Loss of Life the Insured's Principal Sum
Loss of Two or More Members the Insured's Principal Sum
Loss of Speech and Hearing the Insured's Principal Sum
Loss of One Member 1/2 of the Insured's Principal Sum
Loss of Speech or Hearing 1/2 of the Insured's Principal Sum
Loss of Thumb and
Index Finger of the Same Hand 1/4 of the Insured's Principal Sum

DEFINITIONS:

"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

- (1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;
- (2) an eye, Loss means the total and irrecoverable loss of sight;
- (3) speech, Loss means the total and irrecoverable loss of the function;
- (4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;
- (5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.

COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD

DESCRIPTION OF COVERAGE: We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

- (1) attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;
- (2) attending a Service School no matter how long it is, or is enroute to or from that school;
- (3) taking part in any authorized inactive duty training; or
- (4) taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

DEFINITION:

"Service School" means one operated by or on behalf of the United States of America or Canada.

COVERAGE OF EXPOSURE AND DISAPPEARANCE

DESCRIPTION OF COVERAGE

EXPOSURE: Any loss that is due to exposure will be covered as if it were due to Injury, provided such loss results directly and independently of all other causes from accidental exposure to the elements which occurs while the Insured's coverage under the Policy is in force.

DISAPPEARANCE: We will presume an Insured suffered loss of life due to an Injury, if:

- (1) while covered under the Policy, such Insured is riding in a conveyance that is involved in an accident, not excluded from coverage;
- (2) the conveyance is wrecked, sinks or disappears as a result of such accident; and
- (3) the Insured's body is not found within 1 year of the accident.

SEAT BELT AND AIR BAG BENEFIT

DESCRIPTION OF COVERAGE: We will pay a sum equal to 10% of the Insured Person's Principal Sum if:

- (1) the Insured dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;
- (2) a police report establishes that the Insured was properly strapped in a Seat Belt at the time;
- (3) Loss of Life benefits are payable for the Insured's death hereunder.

We will pay an additional 5% if the Insured is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is \$100,000.

No benefit will be paid for any loss sustained:

- (1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or
- (2) if the Insured is not wearing a Seat Belt for any reason; or
- (3) while the Insured is sharing a Seat Belt; or
- (4) due to a defect in the Supplemental Restraint System's diagnostic system.

DEFINITIONS:

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint and includes a government approved child restraint device when used in accordance with manufacturer's directions. In the case of small children the restraint must:

- (1) meet the standards of the National Safety Council; and
- (2) must be properly secured and utilized in accordance with applicable State law and the recommendations of its manufacturer for children of like age and weight.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

- (1) a private passenger automobile; or
- (2) a station wagon; or
- (3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or
- (4) a self-propelled motor home.

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage, and that of any Insured Dependents, to continue for up to 12 weeks in a 12 month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

- (1) To provide care after the birth of a son or daughter; or
- (2) To provide care for a son or daughter upon legal adoption; or
- (3) To provide care after the placement of a foster child in your home; or
- (4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
- (5) To take care of your own serious health condition.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave is to begin; and (3) the date it is expected to end; and (4) must be received by us within 31 days after a claim for benefits has been filed with us.

If you are granted a Family and Medical Leave of Absence, the following applies to you:

- (1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.
- (2) Coverage will terminate for you and any Insured Dependents if you do not return to work as scheduled according to the terms of your agreement with the Policyholder; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond 12 weeks in a 12 month period. Insurance will not be terminated for an Insured who becomes Totally Disabled during the period of the leave and who is eligible for benefits according to the terms of the Policy.
- (3) This extension is not available if you convert your coverage under the Conversion Privilege.

- (4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively At Work in all instances unless such leave is due to your own illness, injury or disability. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective if you are not Actively at Work until such time as you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE COVERAGE

We will allow your coverage, and that of any Insured Dependents, to continue for up to 12 weeks in a 12 month period, if you enter the military service of the United States. While you are on Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective until you have returned to work from a Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during the continuation period. Your continued coverage, and that of any Insured Dependents, will cease on the earliest of the following dates:

- (1) the date the Policy terminates; or
- (2) the end of the period for which premium has been paid for your coverage; or
- (3) 12 weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared) and is also subject to any other exclusions listed in the Exclusions provision.

EXCLUSIONS

The Policy does not cover any loss:

- (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- (2) caused by suicide, or intentionally self-inflicted injuries; or
- (3) caused by or resulting from war or any act of war, declared or undeclared; or
- (4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or
- (5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
 - (a) the Insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
 - (b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or
- (6) sustained during the Insured's commission or attempted commission of an assault or felony.

**ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION LAW**

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

**ILLINOIS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION**

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

**Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(773) 714-8050**

**Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515**

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

A. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- (1) life insurance, health insurance, and annuity contracts;
- (2) life, health or annuity certificates under direct group policies or contracts;
- (3) unallocated annuity contracts; and
- (4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed

entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

B. Exclusions from Coverage:

- (1) The Guaranty Association does not provide coverage for:
 - (a) any policy or portion of a policy for which the individual has assumed the risk;
 - (b) any policy of reinsurance (unless an assumption certificate was issued);
 - (c) interest rate guarantees which exceed certain statutory limitations;
 - (d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
 - (e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
 - (f) any stop loss insurance.
- (2) In addition, persons are not protected by the Guaranty Association if:
 - (a) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
 - (b) their policy was issued by an organization which is not a member insurer of the Association.

C. Limits on Amount of Coverage:

- (1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
 - (a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
 - (b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
 - (i) in the case of life insurance, \$300,000 in death benefits but not more than \$100,000 in net cash surrender or withdrawal values;
 - (ii) in the case of health insurance, \$300,000 in health insurance benefits, including net cash surrender or withdrawal values; and

- (iii) with respect to annuities, \$100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$5,000,000 in benefits per contract holder, regardless of the number of contracts.
- (2) However, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.

**Claim Procedures and
ERISA Statement of Rights**

**CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002**

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims

In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that

notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where

applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;

3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual

conducting the appeal shall consult with a health care professional:

- (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
- (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of

45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and

free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit

determination;

- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the

copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your

rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

RELIANCE STANDARD

Life Insurance Company

a **DELPHI** company

Home Office: Chicago, Illinois
Administrative Office: Philadelphia, Pennsylvania

VAR 203404
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