UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP TERM LIFE BENEFITS

FOR EMPLOYEES OF:

2nd Adventure Payroll Services

CLASS(ES):

All Eligible Hourly Employees

EFFECTIVE DATE:

January 1, 2025

PUBLICATION DATE:

January 10, 2025

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. THE POLICY IS ISSUED IN THE STATE OF IOWA AND PROVIDES ALL THE BENEFITS REQUIRED BY APPLICABLE IOWA LAW.

FRAUD WARNING
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE(S)

If you have any questions about or concerns with this insurance, please first contact the Policyholder or your benefits administrator. If, after doing so, you still have a question or concern, you may contact us at:

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting us, please have your Policy number available.

FOR RESIDENTS OF FLORIDA

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED BY THE LAW OF A STATE OTHER THAN FLORIDA.

FOR RESIDENTS OF NORTH CAROLINA

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN NORTH CAROLINA. PLEASE READ YOUR POLICY CAREFULLY.

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition in the Definitions section.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of you 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 Living Benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect your, your Spouse's 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 your, your Spouse's or your family's eligibility for public assistance.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-CMKF (the Policy) has been issued to 2nd Adventure Payroll Services (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if you are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without your consent or notice to you.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jay C. Vanbeat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

CLASS(ES)

All Eligible Hourly Employees

LIFE INSURANCE BENEFITS

If you die while insured under the Policy, we will pay the amount of life insurance in effect at the time of your death to your beneficiary.

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is $50,000.

Your amount of life insurance is subject to any reductions indicated in the BENEFIT REDUCTIONS provision in this Schedule. If you have questions regarding the amount of your life insurance, you may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the BENEFIT REDUCTIONS provision in this Schedule. If you have questions regarding the amount of your AD&D insurance, you may contact the Policyholder.

EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

BENEFIT REDUCTIONS

As you grow older, the amount of life and AD&D insurance for you will be reduced according to the following schedule:

At the Attained Age of:	The Original Amount of Insurance Will Reduce to:
65	65%
70	50%

Reductions become effective on the Policy Anniversary that coincides with or follows the day you reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If you are age 65 or older on the date insurance becomes effective, the amount of life and AD&D insurance for you will be reduced as shown above. Thereafter, the amount of life and AD&D insurance will continue to reduce in accord with the schedule above.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you are Actively Working on the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not Actively Working on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance on the day you begin Active Work.

The day you become eligible for insurance may not be the same as the day your insurance begins. The WHEN YOUR INSURANCE BEGINS provision describes the day your insurance begins.

WHEN YOUR INSURANCE BEGINS

You become insured for any amount of insurance that does not require Evidence of Insurability on the first day of the month that coincides with or follows the latest of the day:

a) you become eligible and are Actively Working; or
b) your Written Request is properly completed and signed, if required.

You must provide Evidence of Insurability if it is required. You become insured for any amount of insurance that requires Evidence of Insurability, including any amount of insurance in excess of the Guarantee Issue Amount, on the first day of the month that coincides with or follows the day we approve Evidence of Insurability.

EXCEPTIONS TO WHEN YOUR INSURANCE BEGINS

This provision does not apply if you are eligible for insurance under the CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER provision.

If you are:

a) not Actively Working due to Injury or Sickness;
b) Totally Disabled;
c) confined in a Hospital as an inpatient;
d) confined or assigned to a bed as a resident inpatient in any institution or facility other than a Hospital; or
e) confined at home and under the care or supervision of a Physician;

on the day insurance would otherwise begin, insurance will not take effect until the day after you are released by your Physician and you return to Active Work.

If you are not Actively Working when insurance would otherwise begin for reasons other than those listed above, insurance will not take effect until the day you return to Active Work.

WAIVER OF COVERAGE

You may waive coverage:

a) for religious or faith-based reasons;
b) to avoid possible federal and/or state income tax liability; or
c) for any other reason approved by us.

You must submit a Written Request to waive coverage. The request must be signed by you, and in community property states, your Spouse, if applicable. The waiver is effective on the date we receive and record the Written Request.

The waiver is irrevocable for one year from the date we record it. After one year, you may elect coverage by providing Evidence of Insurability at your own expense. You are eligible for insurance if we approve Evidence of Insurability.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

If the Policy replaces a Prior Plan, the Policy will provide insurance for you if you:

a) were insured under the Prior Plan on the day before the Policy Effective Date;
b) are otherwise eligible, but not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) are not insured under any provision of the Prior Plan;
d) are not a retired Employee;
e) are not Totally Disabled on the Policy Effective Date; and
f) are approved by our authorized representative in our home office for insurance under this provision.

Insurance under this provision is subject to the following conditions:

a) insurance may not exceed your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) the benefit payable will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify us in writing prior to the Policy Effective Date of the amount of your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to us when due; and
e) insurance is subject to any reductions shown in the Schedule section of this Certificate and all other terms and conditions of the Policy.

We reserve the right to request any information we need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day you return to Active Work for the Policyholder or begin employment with any other employer;
b) the last day you would have been insured under the prior Plan, if the Prior Plan had not ended or terminated;
c) the day your insurance ends for any reason shown in the WHEN INSURANCE ENDS provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If your insurance under this provision ends and you have not returned to Active Work, you may be able to obtain insurance under the CONVERSION provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class or amount of insurance, whether requested by you or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, unless otherwise stated or allowed in the Policy.

For any increase in insurance, we will use the Policyholder's records and/or the premium we receive to verify that the amount of insurance requested is the appropriate insurance amount the Insured Person is eligible for under the terms of the Policy.

If you are not Actively Working on the day any increase in insurance would otherwise take effect, the increase becomes effective the first day of the month that follows the day you return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that follows the date you become eligible for insurance. If you are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance becomes effective on the day you return to Active Work.

Involuntary Reduction in Hours

If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated if you return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination

If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated if you are rehired and return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence

If insurance ends because you are no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended upon return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of your discharge from active duty without satisfying another Eligibility Waiting Period.

Transfer From Conversion

If insurance is obtained under the CONVERSION provision while you are not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any Conversion policies issued to you must be surrendered to us. If Conversion policies are not surrendered, Evidence of Insurability will be required to reinstate insurance.

WHEN INSURANCE ENDS

Insurance ends:

a) for all Insured Persons on the day you are no longer Actively Working;
b) the day an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less), unless otherwise allowed in the Policy;
c) the day the Policy terminates; or
d) in accordance with the Grace Period provisions.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you would otherwise end, you may be able to continue or obtain insurance under one of the following provisions:

a) CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH
b) CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS
c) CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY
d) CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM
e) CONVERSION

CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

You may be able to continue insurance from the day you cease to be Actively Working in the event of:

a) a temporary involuntary layoff;
b) a temporary furlough; or
c) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision is subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for your temporary involuntary layoff;
    2. 12 weeks for your temporary furlough;
    3. 12 weeks for your leave of absence due to any personal reason; or
    4. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.
b) the amount of insurance may not be increased while insurance is continued under this provision;
c) we receive verification of the approved layoff, leave or furlough from the Policyholder upon request; and
d) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

Insurance under this provision ends on the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) your temporary involuntary layoff or furlough becomes permanent;
c) you return to Active Work;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

If continued insurance under this provision ends and you have not returned to Active Work, you may be able to continue or obtain insurance under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision or CONVERSION provision.

If your leave is due to an Injury or Sickness which may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 6 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

When your insurance would otherwise end because you are no longer Actively Working due to your Injury or Sickness, you may be able to continue insurance under this provision. The total continuation period under this provision and the CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH provision will not exceed 12 months.

Insurance may be continued under this provision if the following conditions are satisfied:

a) we receive verification of your Injury or Sickness from the Policyholder upon request; and
b) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision ends on the earliest of the day:

a) that is 12 months from the day you cease Active Work;
b) you return to Active Work;
c) you begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

If continued insurance under this provision ends and you have not returned to Active Work, you may be able to continue or obtain insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision,

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision or CONVERSION provision.

If your leave is due to an Injury or Sickness which may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 6 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payment section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

When your insurance ends under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision, you may be able to continue insurance under this provision due to your Partial Disability.

Insurance may be continued under this provision if the following conditions are satisfied:

a) you are Partially Disabled, but not Totally Disabled;
b) we receive verification of your Partial Disability from the Policyholder upon request; and
c) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the day:

a) that is 12 months from the day you become eligible for insurance under this provision;
b) you return to Active Work;
c) your Injury or Sickness results in your Total Disability and you are eligible to continue insurance under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the GRACE PERIOD provision.

If continued insurance under this provision ends and you have not returned to Active Work, you may be able to obtain insurance under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision or CONVERSION provision.

If your Partial Disability may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 6 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

This provision only allows for continuation of life insurance. Accidental death and dismemberment insurance may not be continued under this provision.

When your insurance ends under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision or CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision, you may be able to continue insurance under this provision due to your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to us, your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of your potential Total Disability on our total disability claim form within 6 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) you are Totally Disabled;
b) you were under age 60 at the time you became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

If you are age 60 or older and become Totally Disabled, you may be able to obtain insurance under the CONVERSION provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 6 consecutive months. You do not have to be Totally Disabled while satisfying the Disability Elimination Period. Any period of time in which you are insured under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision will apply toward satisfaction of the Disability Elimination Period provided premiums are paid by you or on your behalf. Your insurance will continue during the Disability Elimination Period.

If your group life insurance ends before you are able to satisfy the Disability Elimination Period, you may be able to obtain insurance under the CONVERSION provision until the Disability Elimination Period is satisfied. If your continuation of insurance for Total Disability is approved, your insurance will be continued for the amount of life insurance in effect for you under the Policy on the last day of Active Work, subject to any reductions shown in the Schedule, you must surrender your Conversion policy and any premiums paid for such policy will be refunded.

Proof of Total Disability

You must submit to us acceptable proof of Total Disability approved by our authorized representative in our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that you are Totally Disabled, we have the right to have you examined by a Physician of our choice at our expense.

If you are approved for continuation of insurance under this provision, we will periodically require proof of continuing Total Disability. We may have you examined by a Physician of our choice at any time during the first two years of Total Disability and once a year thereafter at our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify you in writing if your proof of Total Disability is approved by us.

Once you are approved for insurance under this provision, a recurrent disability caused by, resulting from or contributed to by the prior Total Disability will be treated as part of your prior claim and you will not be required to satisfy another Disability Elimination Period if:

a) you were continuously insured for the period between your prior claim and your recurrent disability; and
b) your recurrent disability occurs within 6 months of the end of your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify you in writing if your proof of Total Disability is not approved by us. If at any time while you are insured under this provision we determine that you are no longer Totally Disabled, we will notify you in writing that you are no longer eligible to continue insurance under this provision.

If you are ineligible for insurance under this provision or your insurance under this provision ends, you will have 31 days from the date of our notice to submit a Written Request for insurance under the CONVERSION provision, if you have not returned to Active Work or you are not eligible for insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision.

When Insurance Under this Provision Ends

Insurance under this provision will end on the day:

a) you are eligible to continue insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision; or
b) you return to Active Work.

Insurance under this provision will also end on the earliest of the day:
a) you are no longer Totally Disabled;
b) that is 90 days after the date of our request to you for proof of Total Disability if such proof has not been received by us;
c) you fail to obtain an examination from a Physician of our choice as described in the PROOF OF TOTAL DISABILITY provision by a date established by us;
d) you reach your Social Security Normal Retirement Age; or
e) you begin full-time employment with an employer other than the Policyholder.

In no event will insurance under this provision end less than one year from the day your Total Disability is approved by us.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

If group life insurance ends because your employment or membership in a class (as shown under Class(es) on the Schedule section of this Certificate) ends or your benefit amount reduces you may apply for an individual policy of life insurance other than term insurance ("Conversion Policy").

The Conversion Policy issued under this provision will be:
a) any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits; and
c) for an amount of life insurance that is up to the amount of life insurance that ended or was reduced, less the amount of any other group life insurance the applicant becomes eligible for within 60 days after insurance ended or was reduced.

Premium is based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 60 days after the date insurance ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 60 days from the date insurance would otherwise end or reduce (Conversion Period). When insurance would otherwise end, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time to apply for continued insurance under this provision will be allowed. Any extension will expire on the earlier of:
a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If you are entitled to obtain a Conversion Policy and die within 60 days after insurance ends or reduces, we pay the amount of life insurance which could have been converted, even if you did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You must submit a Written Request for insurance under this provision. The Written Request and the initial premium due must be submitted to us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If you are issued a Conversion Policy and again become eligible for insurance, insurance will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to us. If Conversion Policy(ies) are not surrendered, Evidence of Insurability will be required.

LIVING BENEFITS (ACCELERATED BENEFIT)

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

This section only applies to the life insurance offered by the Policy. Accidental death and dismemberment (AD&D) insurance is not included under this section.

The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting Living Benefits.

ABOUT LIVING BENEFITS

If you incur a Terminal Condition while insured, you, your Spouse or your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for you in effect at the time of the request or $37,500, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for you at the time of the request or $1,000, whichever is greater.

We will pay Living Benefits to you in a lump sum, provided you are living at the time payment is made.

The amount of life insurance benefits payable for you in the event of death will be reduced by the amount of Living Benefits paid for you. Payment of Living Benefits has no effect on accidental death and dismemberment (AD&D) insurance benefits.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, you, your Spouse or your legal representative must provide us:

a) a Written Request for Living Benefits; and
b) satisfactory proof of your Terminal Condition, including an attending Physician's written statement.

You, your Spouse or your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for you only once;
b) you can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision; and
d) the amount of insurance you may obtain under the CONVERSION provision will be reduced by the amount of Living Benefits paid for you.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when you have irrevocably assigned life insurance;
b) if such benefits were paid under a Prior Plan;
c) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
d) during any Conversion Period;
e) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
f) if requested after insurance ends; or
g) if requested after the Policy terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

EXPOSURE AND DISAPPEARANCE

An Insured Person is presumed to have died, for the purposes of accidental death and dismemberment insurance, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

Any loss that is due to exposure is covered as an Injury, provided such loss results directly from accidental exposure to the elements, is independent from all other causes and occurs while the Insured Person's coverage is in force.

BENEFITS

Basic Benefits

If an Insured Person sustains one or more Injuries or dies as a result of an Accident, we will pay the benefit shown in the following table based upon the amount of the Principal Sum in effect at the time of the loss. If an Accident causes more than one loss shown in the table, we will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-quarters Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum

Benefits for your insurance are payable to you or to the beneficiary for life insurance, unless otherwise indicated in a benefit provision included in this section.

Airbag Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $5,000 if an Insured Person dies as the result of an Accident from one or more Injuries sustained while driving or riding in the front seat of an Automobile directly behind an Airbag. This benefit amount is payable in addition to any other applicable benefits. A copy of the police accident report must be submitted with the claim. We will not pay this benefit if the Accident occurs while the Airbag was disengaged. This benefit amount is payable in addition to any other applicable benefits.

Common Carrier Benefit

We will pay a benefit amount equal to 100% of the Principal Sum if an Insured Person dies as the result of an Accident that occurs while a fare-paying passenger on a Common Carrier. This benefit amount is payable in addition to any other applicable benefits.

We will not pay this benefit if the Insured Person was an operator or member of the crew on the Common Carrier at the time of the Accident.

Seat Belt Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $5,000 if an Insured Person dies as the result of an Accident from one or more Injuries sustained while driving or riding in an Automobile and wearing a Seat Belt.

This benefit amount is payable in addition to any other applicable benefits. A copy of the police accident report must be submitted with the claim. We will not pay this benefit if the Accident occurs while the Seat Belt was being used to restrain more than one person, or if the Seat Belt was an automatic Seat Belt and the lap belt was not fastened.

Childcare Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 per year, for Childcare if you die as the result of an Accident and expense is incurred by you, your Spouse or a legally appointed guardian of the child after the death for one or more Dependent children under the age of 12 attending a Childcare center.

This benefit is payable monthly for up to 2 years for each Dependent child to the individual that incurs the Childcare expense. This benefit amount is payable in addition to any other applicable benefits.

A Dependent child does not have to be insured for this benefit to be payable. If both parents of the Dependent child are insured, benefits under this provision will be limited to payment under only one parent. Proof of the expense incurred for Childcare must be submitted with the claim.

Child Education Benefit

We will pay a benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 per year, for the education of a Student if you die as the result of an Accident.

The Dependent child must become a Student within 365 days after the Accident (if not already a Student). The Student must continue to be enrolled for each consecutive term for the benefit to be payable. This benefit is payable to the Student or, if a minor child, to the individual that incurs the education expense, at the end of each school term for up to 4 consecutive years for each Student. This benefit amount is payable in addition to any other applicable benefits.

A Dependent child does not have to be insured for this benefit to be payable. If both parents of the Dependent child are insured, benefits under this provision will be limited to payment under only one parent. A copy of the Student's most recent grade report and tuition statement must be submitted with the claim.

For purposes of this benefit, the term Student does not include a Dependent child attending high school.

Spouse Education Benefit

We will pay a benefit amount of $3,000 per year, for the education of your Spouse at an accredited trade school, college, university or other institution of higher learning if you die as the result of an Accident.

Your Spouse must become a full-time student within 365 days after the Accident (if not already a student). Your Spouse must continue to be enrolled as a full-time student for each consecutive term for the benefit to be payable. This benefit is payable to your Spouse at the end of each school term for up to 4 consecutive years. This benefit amount is payable in addition to any other applicable benefits.

Your Spouse does not have to be insured for this benefit to be payable. A copy of your Spouse's most recent grade report and tuition statement must be submitted with the claim.

Coma Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum. Benefits will be payable to the Insured Person's legal representative or legally appointed guardian at the end of the month for up to 20 months if:

a) the Insured Person sustains one or more Injuries as the result of an Accident and becomes Comatose within 31 consecutive days of the Injury; and
b) the Insured Person remains Comatose for 31 consecutive days.

If the Insured Person's Glasgow Coma Score temporarily becomes nine (9) points or higher and then reverts to eight (8) points or less, this will not cause a discontinuance in the benefit payment if the lapses and subsequent Coma recurrences are due to the same Injury.

Benefits will be payable until the earlier of:

a) the end of the month in which the Insured Person is no longer Comatose; or
b) the end of the month in which the Insured Person dies.

EXCLUSIONS

We will not pay for any loss which:

a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
b) results from an Insured Person's voluntary Participation in a Riot, commission of or attempt to commit a felony, participation in illegal activities or participation in an illegal occupation;
c) occurs while an Insured Person is incarcerated or imprisoned;
d) results from an act of declared or undeclared war or armed aggression;
e) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
f) is not permanent, unless specifically provided;
g) occurs more than 365 days after the Injury, except that this 365 day limit will not apply if an Insured Person is Comatose or being kept alive by an artificial support system at the end of the 365 days;
h) does not result from an Accident;
i) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
j) occurs when an Insured Person is operating, learning to operate, riding as a passenger, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly scheduled flight or while Traveling on Business of the Policyholder;
k) occurs while an Insured Person is riding in or on any motorized vehicle or aircraft engaged in racing, endurance tests, off-road activities (for motorized vehicles), acrobatic tricks or stunts (for motorized vehicles), or acrobatic or stunt flying (for aircraft);
l) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
m) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing or other similar high risk activities or extreme sports;
n) is caused by the Insured Person, and is a result of Injuries the Insured Person receives due to:
    1. the voluntary use of illegal drugs;
    2. the intentional taking of over the counter medication not in accordance with recommended dosage and warning instruction; or
    3. the intentional misuse of prescription drugs;
o) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE

When insurance is continued we must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premium; or
b) you may pay premium to the Policyholder who will then submit premium to us.

Contact the Policyholder to determine which option is available to you.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

There is a grace period of 31 days for payment of premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate for each coverage option shown in the Schedule section of this Certificate.

The premium for insurance under the Policy is paid (in full) by the Policyholder. Contact the Policyholder for additional information on the current premium for the Policy.

If you request a change in the amount of insurance, the Policyholder will provide you with notice of your new premium amount upon request if you are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, or a change in the amount of insurance as the result of a request of the Policyholder, the Policyholder will provide you with notice of the change at least 15 days prior to the date of the change if you are responsible for the payment of premium for insurance.

Premium amounts will change if:

a) you reach an age when benefits are reduced as described in the BENEFIT REDUCTIONS provision in the Schedule section of this Certificate; or
b) premium rates under the Policy are changed.

CLAIMS PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

CLAIM FORMS

Before benefits are considered, we must be given written proof of loss. A claim form can be requested from the Plan Administrator, from us or obtained on our website.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days from the date of loss. If it is not reasonably possible to give us proof within the required time, we will not reduce or deny a claim for this reason if the proof is supplied as soon as reasonably possible.

INDEPENDENT EXAMINATION AND AUTOPSY

We may require an Insured Person to be examined by a Physician as we direct to assist in determining whether benefits are payable. You may not impose any conditions on an examination such as pre-approval of the examiner, attendance of a third party or audio/video recording of the examination.

We will pay for these examinations; however, you may be responsible for fees associated with failure to notify the examination office of your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reducing benefits that are payable. We will not require more than a reasonable number of examinations. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written proof of loss and any other required supporting information.

Unless you have assigned this insurance, benefits for any Insured Person will be paid to you, except benefits payable due to your death will be paid to:

a) your designated beneficiary(ies); if none, then to
b) your surviving Spouse; if none, then to
c) your surviving natural and/or adopted children, in equal shares; if none, then to
d) your surviving parents, in equal shares; if none, then to

e) your estate.

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

We will notify the Claimant in writing of our decision to either approve or deny a claim within:

a) 90 days of the date a life or accidental death and dismemberment claim is received by us; or
b) 45 days of the date a continuation of insurance for total disability claim it is received by us.

If we deny a claim in whole or in part, we will explain the reasons for our denial in our notice. If the Claimant disagrees with the reasons given, the Claimant, or authorized representative of such person, may ask that we reconsider the claim through the appeal process.

Appeal Process

To appeal a denied claim, the Claimant must notify us and ask that we reconsider our original benefit decision within:

a) 60 days after receiving notice of our denial of a life or accidental death and dismemberment claim; or
b) 180 days after receiving notice of our denial of a continuation of insurance for total disability claim.

The Claimant's appeal request must be submitted to us in writing or electronically and should state the reasons the Claimant believes the claim denial was incorrect. Any additional information, documents or other materials that might allow us to change our original decision should also be included. Appeal requests must be sent to us at our Omaha, Nebraska address shown in the CLAIMS ASSISTANCE provision.

We will notify the Claimant in writing of our final claim decision within:

a) 60 days after receiving a life or accidental death and dismemberment appeal request; or
b) 45 days after receiving a continuation of insurance for total disability appeal request.

If we need more time due to circumstances beyond our control, we will inform the Claimant of our need for an extension prior to the end of this time frame.

Notice

If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Claimant may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of a claim or to ask questions about the Claimant's rights under ERISA.

BENEFICIARY DESIGNATION

In the event of your death, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

Certain states are community property states. If you live in a community property state and you designate someone other than your Spouse as a beneficiary, state law may require that your Spouse consent to such designation. If you do not obtain your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Your beneficiary may be changed at any time by you or your assignee (if you have assigned this insurance). To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by us before the Written Request was communicated to us by the Policyholder.

FACILITY OF PAYMENT

We may pay an amount of up to $500 to any person or entity that has incurred expenses related to your death and subsequent burial. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

MODE OF PAYMENT

Life insurance benefits will be paid by us in one lump sum. Accidental death and dismemberment benefits will be paid in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits section of this Certificate.

REFUND TO US

If it is found that we paid more benefits than we should have paid under the Policy, we will have the right to a refund from you or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error we make in processing a claim;
c) you or your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse us in full. We will determine the method the repayment is to be made, including without limitation, reducing or withholding any benefits payable to you, your survivors or your estate under this or any other group insurance policy issued by us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that we paid less benefits than we should have paid under the Policy, we will make additional payments, as necessary.

AUTHORITY TO INTERPRET POLICY

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

By purchasing the Policy, the Policyholder grants us the discretion and the final authority to construe and interpret the Policy. This means that we have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by us. Benefits under the Policy will be paid only if we decide, in our discretion, that a person is entitled to them. In making any decision, we may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Policyholder further grants us the authority to delegate to third parties, our affiliates and any third party administrator with whom we have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to us under this Policy.

The Insured Person or beneficiary has the right to request a review of our decision. If, after exercising the Policy's review procedures, the Insured Person or beneficiary's claim for benefits is denied or ignored, in whole or in part, the Insured Person or beneficiary may file suit and a court will review the Insured Person or beneficiary's eligibility or entitlement to benefits under the Policy.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (which includes this Certificate);
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for you.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by our authorized representative in our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not contest this Policy after it has been in force two years, during an Insured Person's lifetime, except for nonpayment of premium.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless we provide you, your beneficiary or legal representative with a copy of that application.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after we have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in your state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provisions of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

DEFINITIONS

The defined terms used in this Certificate and Policy are shown in this section. With the exception of *our*, *we, us, you* and *your*, we have capitalized these terms wherever they appear to make them easier for you to find.

The definitions set forth below apply to both the singular and plural versions of the defined term.

Accident, Accidental means a sudden, unexpected and unforeseeable event resulting in one or more Injuries that occurs after the Policy Effective Date and while insurance is in effect for an Insured Person. Accident does include bacterial infection that is the natural and foreseeable result of an accidental Injury or accidental food poisoning.

If the Policyholder's rules of eligibility for insurance conflict with any of the terms and conditions of the Eligibility section of this Certificate, the terms and conditions of the Eligibility section control. Any changes to the Policyholder's rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance unless such changes have been approved by our authorized representative in our home office.

Actively Working, *Active Work* means you are:

a) performing the normal duties of your job for the Policyholder on a regular and continuous basis 30 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

You will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided you were actively working on the last preceding regular work day.

Airbag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

Automobile means an appropriately licensed private passenger motor vehicle for use on public roadways.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Childcare means care provided for each Dependent child on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided by an adult other than a person who is part of the Insured Person's Family.

Claimant means the person who submits a claim for benefits for any Insured Person, including the authorized representative of such person.

Coma, Comatose means the Insured Person is in a profound stupor or state of complete and total unconsciousness with a Glasgow Coma Score of eight (8) points or less, requiring intubation for respiratory assistance. A coma does not include a medically induced coma or a coma that is the result of any alcohol or drug abuse.

Common Carrier means a method of common public transport with defined published routes, time schedules and rates approved by regulators. A common carrier includes public airlines, railroads, subways, trolleys, boats and bus lines. A common carrier does not include taxis, limousines, any privately chartered mode of transportation or any mode of transportation owned, operated or leased for by the Policyholder.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) your Spouse;
b) your natural born, legally adopted child or foster child;
c) your stepchild;
d) a child that you or your Spouse are required to provide insurance for under the terms of a decree, judgment or order issued by a court of competent jurisdiction; or
e) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);

c) your divorced, legally separated or former Spouse;
d) your child who is married (or in a domestic partnership, civil union partnership or equivalent);
e) a stillborn child;
f) your child if the child has been legally adopted by another person; or
g) a child placed in your home by a social service agency which retains control over the child.

Disability Elimination Period means the period of time that must be satisfied before you are eligible to continue benefits, beginning on the date your Injury or Sickness occurred. The length of the disability elimination period is shown in the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision.

Dismemberment means the removal of a body part by trauma, prolonged constriction, or surgery (amputation).

Eligibility Waiting Period means a continuous period of Active Work that you must satisfy before becoming eligible for insurance as described in the WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD) provision.

Employee means a person who is:
a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:
a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from our authorized representative in our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by us.

Family means Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners, civil union partners or equivalent) of such individuals.

Hospital means a facility that is accredited, approved, certified or licensed as a general hospital by the proper authority of the state in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part thereof which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical disability.

Injury means bodily harm that:
a) is a direct result of an Accident requiring treatment by a Physician;
b) is independent of bodily infirmity, Sickness or medical or surgical treatment and all other causes; and
c) occurs after the Policy Effective Date and while insurance is in effect for an Insured Person.

Insured Persons means you who is insured under the Policy.

Intoxicated means having a blood alcohol or drug level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle as defined by the laws of the state where the Accident occurs.

Living Benefits means an advance payment of part of your life insurance death benefit.

Loss of Both Feet, Loss of One Foot means Severance of the foot or both feet above the ankle joint. Loss of a foot includes the Severance of an entire leg or Severance of any part of a leg that includes an entire foot.

Loss of Both Hands, Loss of One Hand means Severance of at least four whole fingers from one hand or both hands. Loss of a hand includes the Severance of an entire arm or Severance of any part of an arm that includes an entire hand.

Loss of Entire Sight of Both Eyes, Loss of Entire Sight of One Eye means total and permanent loss of sight in one or both eyes which cannot be corrected by any means, or Severance of one or both eyes.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Speech means total and permanent loss of audible communication which cannot be corrected by any means.

Loss of a Thumb and Index Finger of same Hand means Severance of the thumb and index finger of the same hand at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Our, We, Us means United of Omaha Life Insurance Company.

Paralysis means total and permanent loss of use of a limb without Severance. This loss must be determined by a Physician to be complete and irreversible. Forms of paralysis include quadriplegia, triplegia, hemiplegia, paraplegia and uniplegia.

Partial Disability, Partially Disabled means that, because of an Injury or Sickness lasting longer than 12 months, you are unable to perform the normal duties of your regular job for the Policyholder on a regular or continuous basis, but are able to satisfy all other requirements of the Active Work definition.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Physician means a legally qualified medical doctor who is licensed to practice medicine, prescribe drugs or perform surgery, or any other licensed healthcare provider who is deemed to be the same as a legally qualified medical doctor. The physician must be acting within the scope of his/her license. A physician does not include the Insured Person or any Family member.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by us, including this Certificate.

Policyholder means 2nd Adventure Payroll Services.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2025.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained, sponsored by or available through the Policyholder on the day before the Policy Effective Date.

Seat Belt means a factory-installed lap and shoulder seat belt or other similar restraint device which meets published federal safety standards.

Severance means the complete separation and Dismemberment of the part from the body.

Sickness means a physical or mental disease, illness, infection, disorder or condition, including pregnancy and any drug or alcohol disorder, that requires treatment by a Physician, occurs after the Policy Effective Date and while insurance is in effect for an Insured Person.

Social Security Normal Retirement Age means your normal retirement age under the U.S. Social Security Act. The Social Security Normal Retirement Age table is available online at www.ssa.gov/OACT/ProgData/nra.html or any other online website address which replaces this address.

Spouse means the person to whom you are legally married.

Student means your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

Terminal Condition means an Injury or Sickness that is expected to result in your death within the next 12 months as certified by an attending Physician's written statement.

Total Disability, Totally Disabled means that because of an Injury or Sickness you are completely and continuously unable to perform any work or engage in any occupation.

Traveling on Business of the Policyholder means any trip made by you on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing him or her to operate the aircraft.

Written Request means a request that is signed, dated and submitted to the Policyholder or us. The request must be on a form we supply or be in a form and content acceptable to us.

You, Your means the Employee who may be eligible or insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with your Certificate, is your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made solely by the Policyholder. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The Plan provides coverage for more than one class of Employees.

The benefits under the Plan are fully insured by us under a group insurance policy issued by us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at 3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 93-3924219
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

2nd Adventure Payroll Services
3006 Brownells Pkwy
Grinnell, IA 50112
Phone: (641) 632-8018

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

2nd Adventure Payroll Services
3006 Brownells Pkwy
Grinnell, IA 50112
Phone: (641) 632-8018

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

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

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts 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.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. 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.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer 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.

c) 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 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 in 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.

d) 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.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Term Life Benefits

2nd Adventure Payroll Services

Group Number: G000CMKF

United of Omaha Life Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

