Welcome

Get the most out of your life insurance benefits.

Caring for your loved ones starts with financial and emotional support.

UnitedHealthcare®

The decision to get life insurance can sometimes be tough, but it's a good feeling to know you've provided financial and emotional support for your loved ones in case of your unexpected death.

Use this guide to learn about the many services you get with your plan and how you and your loved ones can access them.

About your life insurance plan.

Your life insurance plan is a term life policy that will pay a cash benefit directly to your designated beneficiaries if you should pass away. Your beneficiary can use the money to help cover costs like funeral expenses, mortgage, and education.

For your specific plan details, including the length (term) of your policy, please see your certificate of coverage.

24/7 support for you and your beneficiaries.

Your plan includes many resources and personal support services to help you prepare and to help your loved ones cope. These services are available 24/7 and at no additional cost.

For personal and confidential assistance,

call **1-866-302-4480**, TTY **711**.
Translators are available.

Get help anonymously

at **liveandworkwell.com**
Use access code: **LIFEBENSVS**.
This secure, online resource can help you locate providers, community and grief support resources and learn about timely and important life topics.

Maintaining your privacy and confidentiality is of utmost importance. All records, referrals and evaluations are kept private in accordance with federal and state laws.

Will and trust preparation

Creating a will and trust may help give you more control over future events and allows the family to follow your wishes. Your life insurance plan includes online will and trust services to help you:

- Create and prepare a will — registration required.
- Locate nearby attorneys, search legal forms, find helpful articles by legal experts and more.
- Access financial planning help and helpful cost calculators.

Prepare your will today.

Go to **liveandworkwell.com**.

1. Enter access code: **LIFEBENSVS**.
2. Select **Financial & Legal tab**.
3. Select **Estate Planning or Retirement Planning**.

Beneficiary services

After a death, there's so much to deal with that it can be overwhelming. It's nice to know your beneficiary will have a team of professionals — included in your plan — ready to help provide emotional, financial and legal guidance. All services are confidential, and specialists are available 24/7.

Grief support:

- Unlimited phone access to masters-level specialists, 24/7.
- Up to 2 referrals for face-to-face grief counseling sessions,[1] with access to a national network of 144,000+ clinicians.[2]

Financial and legal support:

- One 30- to 60-minute financial consultation with a credentialed financial professional who can discuss estate taxes and other financial matters.
- One 30-minute legal consultation. As a beneficiary, you can retain an attorney for ongoing services at a discounted rate.[3]

Wealth management account:

- Option to open a bank account from Optum Bank® for help managing the money. Visit **optumbank.com** to learn more.
- An account automatically opens for payments of $5,000 or more.

Steps to filing a claim.

1. **Notify the employer** about the death of the covered person.
2. **Access the claim packet** at **myuhc.com®** (log in not required).
3. Select **Popular Forms.**
4. Select **Disability, Life and Supplemental Insurance Claim Forms.**

If you need assistance, please call our claim service team at **1-888-299-2070, 8 a.m. to 6 p.m. ET**.

Beneficiary Companion

The Beneficiary Companion Program provides 24/7 guidance for your beneficiary on closing your estate and protecting your identity.

Guidance services:

Help is available anytime to obtain death certificate copies and to notify:

- Social Security Administration
- Credit reporting agencies
- Credit card companies/ financial institutions
- Third-party vendors
- Government agencies

Request the guidebook.

Get assistance or request your complimentary guidebook by calling toll-free **1-866-643-4241.**

Social Media Shut-Down:

It can be a time-consuming process to close your social media accounts. Help is available to:

- Discontinue access to your social media accounts (e.g., Facebook, Instagram, Twitter, LinkedIn, Google properties, etc.).
- Assist with memorialization of specific accounts to preserve your digital profile for friends and family.

Fraud resolution:

Identity theft is a growing risk. Expert help is available to help protect it – and lend a hand if it is stolen. Services include:

- A credit report review.
- Suppression of the credit report or freezing/closing the account.
- Full-service resolution assistance, including affidavit assistance, credit bureau, and fraud department notification, help to file a police report and creditor follow up.

Travel assistance

If you or your beneficiaries travel 100 miles or more away from home or outside the country, call **1-800-527-0218** to access these travel assistance services 24 hours a day, anywhere in the world. Just a few of the services UnitedHealthcare Global travel provides:

Travel assistance services:

- Emergency travel arrangements.
- Assistance in replacing lost or stolen travel documents.
- Emergency translation services.

Medical assistance services:

- Worldwide medical and dental referrals.
- Relay of insurance and medical information.
- Assistance in replacing corrective lenses and medical devices and much more.

Get travel help anytime and on the go.

Log in to **UHCGlobal.com** to print your Global Assistance ID card, get up-to-date travel alerts, travel tips and much more.

Create your account:

1. Select **Member Log-in**.
2. Select **Visit Global Intelligence Center**.
3. Select **Create User** and enter the ID number 358231.

UnitedHealthcare®

[1] Optum internal network analysis, February 2019.

[1] There is no charge for referrals or for seeing a clinician within our network for up to 3 visits per issue.

[2] Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare, its affiliates or any entity through which the caller is receiving services directly or indirectly.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCION: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al numero de telefono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務. 請撥打會員卡所列的免付費會員電話號碼.

All trademarks are the property of their respective owners.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company and certain products in California by Unimerica Life Insurance Company. Life and Disability products are provided on policy forms LASD-POL (05/03) et al. and UHCLD-POL 2/2008 et al., in Texas on forms LASD-POL-TX(05/03) and UHCLD-POL 2/2008-TX and in Virginia on LASD-POL(05/03) and UHCLD-POL 2/2008. The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT and Unimerica Life Insurance Company is located in Milwaukee, WI.

Noninsurance services are offered only on specific lines of coverage and are not insurance. These services may be modified or terminated at any time, may not be available in all states and may vary depending on state laws and regulations. Will and Trust and Beneficiary Services are offered through Optum. Optum is an affiliate of UnitedHealthcare. Travel Assistance services are provided by UnitedHealthcare Global Assistance. Beneficiary Companion is provided by Generali Global Assistance, LLC, a service provider not affiliated with UnitedHealthcare. UnitedHealthcare is not responsible or liable for care, services, or advice given by the provider or vendor of these services.

Facebook.com/UnitedHealthcare **Twitter**.com/UHC **Instagram**.com/UnitedHealthcare **YouTube**.com/UnitedHealthcare

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GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CERTIFICATE OF COVERAGE

For

DAVE'S PLACE

GROUP NUMBER: 1565461

EFFECTIVE DATE: January 1, 2024

LIFE PLAN: BL0088

Offered and Underwritten by

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company

Home Office: 185 Asylum Street, Hartford, Connecticut 06103-3408

Administrative Office: 9900 Bren Road East, Minnetonka, MN 55343

www.uhc.com

CERTIFICATE OF COVERAGE

Policyholder: DAVE'S PLACE

Policy Effective Date: January 1, 2024

Policy Anniversary Date: January 1 of each year

Policy Number: 1565461

UnitedHealthcare Insurance Company (We, Our, Us or the Company), has issued the Policy to the Policyholder shown above.

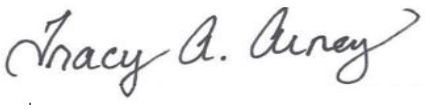
This Certificate replaces any other Certificate previously issued and is incorporated in and made part of the Policy on the Effective Date shown in the Policy's Incorporation Provision.

Read Your Certificate Carefully. If You have questions or need information about Your insurance, call 1-866-615-8727.

Capitalization in this Certificate: Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term or a specific provision herein.

Time Periods: All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Signed for the Company by:



Tracey Arney, Secretary

Jessica Paik, President

Insurance Products: Group Term Life Insurance and Accidental Death and Dismemberment Insurance

Non-Participating (no dividends paid)

Noninsurance Benefits: Noninsurance benefits are not part of Your Certificate and do not modify Your insurance benefits. We may offer or arrange for various entities or vendors to offer benefits or other considerations to You for the purpose of promoting Your general health and well-being. Noninsurance benefits may be modified or terminated at any time. Such modification or termination may be made based on availability of services or other reasons at Our discretion or at the discretion of the insurer or entity providing such services.

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SCHEDULE OF BENEFITS

Policyholder: DAVE'S PLACE

Description of Eligible Class(es): Employees of the Policyholder who are Actively at Work and who are Full-time Employees working at least 30 hours per week.

Employee Waiting Period: 4 Days, subject to the requirements shown in the Eligibility provision

Insurance Funding Information:

Non-Contributory Insurance:

- Basic Life, Accidental Death and Dismemberment Insurance - Your Employer pays the entire premium

Premium Rate Change: Your premium may change on any premium due date if rates for Your Class are changed under the Policy.

Your Benefits and Benefit Amounts are those which You elect at the time You Enroll.

Your Insurance Benefits	**Benefit Information**
Basic Life Insurance Benefit	Benefit Amount: $15,000 Guaranteed Issue Amount: $15,000
Basic Accidental Death and Dismemberment Benefit	24 hour basis Benefit Amount: $15,000
Waiver of Premium Benefit	Applicable to Basic Life Insurance
Accelerated Death Benefit	Up to 50% of Basic Life Insurance Maximum Benefit Amount: $50,000
Additional Life Insurance Benefits	**Benefit Information**
Repatriation Benefit - Life	Maximum Benefit Amount: $15,000
Additional Accidental Death and Dismemberment Benefits	**Benefit Information**
Seat Belt and Airbag Benefit	10% of the Accidental Death and Dismemberment Benefit Amount Maximum Benefit Amount: $10,000

Reduction in Insurance Due to Age

We will reduce the Basic Life Insurance Benefit Amount and Accidental Death and Dismemberment Benefit Amount for You to 65% at age 65 and to 50% at age 70 and will terminate at retirement or as stated in the Covered Person Termination of Insurance, whichever occurs first. These percentages will apply to the current amount of insurance. The reductions will be effective on the first day of the month following the month in which Your birthday occurs.

These reductions will also apply if, after Your reaching age 65:

1. You first become insured under the Policy; or
2. Your insurance increases.

DEFINITIONS

Active Work or Actively at Work means You are performing all the regular duties of Your occupation:

1. at Your usual place of employment or any other business location where You are required to travel;
2. for the entire normal workday; and
3. for at least the minimum number of hours per week, as shown in the Description of Eligible Class(es) in the Schedule of Benefits.

You or Your Employer must provide Us satisfactory documentation that You are Actively at Work in accordance with the Proof of Claim provision.

Unless You are disabled or terminate Your employment on the prior workday or on a day of absence, We will consider You to be Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an approved or emergency leave of absence (except medical leave).

Certificate or Certificate of Coverage means this document, which describes the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Change in Status means any of the following changes:

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Your dependents for tax purposes (birth, legal adoption of a child, placement of a child for adoption, or death of a dependent);
3. certain changes in employment status that affect Your benefit eligibility, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a significant increase in the cost of insurance or a significant reduction of insurance under Your other insurance or Your spouse's insurance; or
5. the addition, elimination, or significant reduction, of an insurance option.

Covered Person means the Employee insured under the Policy and to whom this Certificate is issued.

Employee means a person who works for the Employer on a regular basis:

1. in the normal business of the Employer;
2. is paid for services by the Employer;
3. who resides in the United States, its territories and protectorates; and
4. is Actively at Work for the Employer, or any subsidiary or affiliate insured under the Policy.

Employee does not include temporary, leased or seasonal Employees.

No director or officer of the Employer will be considered an Employee unless they work directly for and receive a salary, from the Employer.

Employer means the Policyholder and:

1. may also include any division, subsidiary, or affiliated company named in the Schedule of Benefits; and
2. does not include any employer who is not the Policyholder.

Enrollment Period means a period of time, determined by the Employer and Us, as described below:

1. Initial Enrollment Period: the period during which You may first enroll for insurance;
2. Re-Enrollment Period: the period during which You may enroll after You have let Your insurance end; or
3. Annual Enrollment Period: the period of time before each Policy Anniversary Date, during which You may enroll for insurance or change Your insurance.

Evidence of Insurability means specific information about You which You provide to Us when applying for insurance. That information includes:

1. a completed and signed application;
2. a medical examination if requested;
3. an Attending Physician's Statement if requested; and
4. any additional information We may require.

Guaranteed Issue Amount means the amount of Life Insurance for which we do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Benefits.

Immediate Family means Your spouse or domestic partner, child, parent or sibling; or Your spouse's or domestic partner's child, parent or sibling.

Injury means bodily injury, which occurs as the result of an accident while insured under the Policy. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or any other cause.

Intoxicated or Intoxication means being under the influence as defined by applicable state law as determined by:

1. the blood alcohol content; or
2. the results of other means of testing blood alcohol content or the content of other substances.

Non-Contributory Insurance means insurance which You do not have to elect nor make any premium contributions.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given; and
3. practicing within the scope of that license.

The term Physician does not include You or members of Your Immediate Family.

Policy means the legal contract between the Policyholder and Us. It may be changed or discontinued without Your or Your Beneficiary's consent. The Policy may be inspected at the office of the Policyholder.

Prior Group Plan means the group Life and accidental death and dismemberment insurance policy carried by the Employer on the day before the Policy's Effective Date.

Sickness means an illness, disease, pregnancy or complication of pregnancy.

Treatment means any consultation, advice, tests, attendance or observation, supplies or equipment, including prescriptions or the use of prescription drugs or medications.

Vocational Rehabilitation Consultant means someone who specializes in the areas of:

1. vocational rehabilitation;
2. vocational and occupational availability in the current labor market; and
3. skills that are needed to perform specific occupations.

The term Vocational Rehabilitation Consultant does not include You or members of Your Immediate Family.

We, Our, Us or the Company means UnitedHealthcare Insurance Company, and its administrators and representatives.

You or Your means the Employee insured under the Policy and to whom this Certificate is issued.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person Eligibility: You will become eligible for insurance on the latest of:

1. the Effective Date of the Policy;
2. the date You complete the required Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include Your Class; or
4. the date You enter a Class eligible for insurance, as shown in the Schedule of Benefits.

Enrolling for Your Insurance Under the Policy:

For Non-Contributory Insurance: Your Employer will automatically enroll You.

Enrollment for Your Basic Life may be subject to the Evidence of Insurability Requirements provision. If You elect Basic Life for the first time or request an increase up to the Guaranteed Issue amount, the election may be subject to the Evidence of Insurability Requirements provision.

During an Annual Enrollment Period, if You do not request changes or re-enroll for insurance, You will continue to be insured for the same insurance amount.

Covered Person Effective Date of Insurance:

If Your insurance is Non-Contributory, and Evidence of Insurability is not required, Your insurance will start on the date You become eligible for insurance, regardless of when You apply.

Any insurance for which Evidence of Insurability is required, will become effective on the later of:

1. the date You become eligible; or
2. the date We approve Your Evidence of Insurability, as stated in Your notification.

All Effective Dates of insurance are subject to the Deferred Effective Date provision.

Deferred Effective Date:

If You are not Actively at Work on the date Your insurance is scheduled to take effect, it will take effect on the date You return to Active Work. If Your insurance is scheduled to take effect on a non-working day, Your Actively at Work status will be based on the last working day before the scheduled Effective Date of Your insurance.

Evidence of Insurability Requirements:

Evidence of Insurability is required, at Your expense, for Your insurance if You:

1. apply more than 31 days after the date You:
   a. first became eligible for insurance; or
   b. have a Change in Status;

   unless You apply during an open enrollment period;
2. apply after You had previously terminated Your insurance while in an Eligible Class, unless You apply due to a Change in Status;
3. apply for insurance and Your Employer has less than 2 Employees; or
4. are under the Waiver of Premium Benefit and return to Active Work for less than 10 days and apply to increase Your Life Insurance.

You must use forms provided by Us when providing Evidence of Insurability.

Evidence of Insurability must be approved by Us in writing for insurance to become effective.

Effective Date of Change in Amount of Insurance: If there is a decrease in the amount of Your insurance, the decrease will take effect on the first day of the month following the change.

If there is an increase in the amount of Your insurance, made during an Annual Enrollment Period, it will be effective on the later of:

1. the date of enrollment;
2. the next Policy Anniversary Date; or
3. the date We approve Your Evidence of Insurability, if required.

A change in insurance due to a Change in Status will be effective on the later of:

1. the date of the Change in Status, if You apply within 31 days after the date of the Change in Status; or
2. the date We approve Your Evidence of Insurability, if required.

A change in insurance that is made other than during an Annual Enrollment Period will be effective on the first day of the month following the change We approve Your Evidence of Insurability.

Once insurance begins, any increase in or addition to insurance will be effective immediately or on the date We approve any required Evidence of Insurability.

Any increase in or addition to insurance for You will be subject to the Deferred Effective Date.

Continuity of Your Insurance Under a Prior Group Plan:

We will waive the Deferred Effective Date requirement for Your initial insurance under the Policy if:

1. On the day before the Policy Effective Date:
    a. You were insured under the Prior Group Plan;
    b. premium for Your insurance under the Prior Group Plan was not being waived due to a waiver of premium provision or You were not eligible under the Prior Group Plan to have premiums waived under a waiver of premium provision; and
    c. You are not receiving or eligible to receive benefits under the Prior Group Plan; and
2. On the Policy Effective Date You:
    a. are not Actively at Work; and
    b. are eligible for insurance except for meeting the Actively at Work requirement.

The benefit amounts and limitations prior to Your return to Active Work will be the same as the benefits under the Prior Group Plan.

We will reduce the amount We pay under the Policy by any benefits still payable under the Prior Group Plan. When You return to Active Work, You will be eligible for the insurance amounts and provisions of the Policy.

Insurance provided pursuant to this provision will not extend beyond the earliest of the following dates:

1. the date Your insurance would end for any reason shown under Covered Person Termination of Insurance provision;
2. the date Your insurance would have ended under the Prior Group Plan had it remained in force; or
3. the last day of a period of 12 consecutive months after the Policy Effective Date.

Any premium received by Us will be refunded:

1. if We determine You are not eligible for waiver of the Deferred Effective Date based on the requirements provided pursuant to this provision; or

2. if receipt of such premium is beyond the termination period stated above for insurance continued pursuant to this provision.

Covered Person Termination of Insurance: Your insurance will terminate on the earliest of the following dates:

1. the last day of the period the required premium is due but not paid, subject to the Grace Period provision;
2. the last day of the month during which You cease to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date You are no longer Actively at Work due to a total disability, unless insurance is continued in accordance with the Waiver of Premium Benefit; or
5. the date You are no longer Actively at Work for any other reason, unless insurance is continued in accordance with the Continuation of Insurance Provisions.

Grace Period: A Grace Period of 31 days will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will continue in effect provided the premium is paid by the Policyholder before the end of the Grace Period. The Grace Period will not continue the insurance beyond a date shown in the Termination of Insurance provision.

CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation of Insurance:

Insurance under the Policy may be continued beyond a date stated in the Covered Person Termination of Insurance provision, according to the Continuation Provisions. The amount of continued insurance applicable to You will be the amount of insurance in effect on the date immediately before insurance would otherwise have ended and is subject to payment of premium. Insurance that is continued:

1. is subject to any reductions stated in the Policy;
2. may be continued up to the maximum time shown in the applicable provision(s); and
3. terminates if the Policy terminates.

The amount of insurance will not increase while insurance is continued under one or more of the following provisions.

Continuation Provisions:

1. leaves of absence must be approved in writing by Your Employer; and
2. when combined, will not extend longer than 3 months from the date You were last Actively at Work.

All other terms of Your insurance under the Policy remain unchanged.

If Your insurance does not continue during an approved Continuation Provision, then when You return to Active Work:

1. You will not have to meet a new Employee Waiting Period; and
2. You will not have to give Us Evidence of Insurability to reinstate the insurance You had in effect before Your continuation began.

Continuation Provisions:

Family and Medical Leave: If You are granted a leave of absence, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your insurance may be continued for up to 3 months following the date Your leave commenced. Continuation may be a longer period if required by any other applicable state or local law. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Leave of Absence: If You are on a medical or non-medical leave of absence, other than Family and Medical Leave or Military Leave of Absence, all of Your insurance may be continued for up to:

1. 3 months from the date You stopped being Actively at Work, with respect to a medical leave of absence; or
2. 3 months from the date You stopped being Actively at Work, with respect to a non-medical leave of absence.

Continuation may be a longer period if required by law.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence, all of Your insurance may be continued for up to 3 months from the date You stopped being Actively at Work or a longer period if required by law.

Sickness or Injury: If You are no longer Actively at Work due to Sickness or Injury, all of Your insurance may continue until the earlier of:

1. the date You return to work; or
2. 3 months from the date You stopped being Actively at Work.

Continuation may be a longer period if required by law.

Layoff: If You are laid off by Your Employer all of Your insurance may be continued for up to 90 days from the date You stopped being Actively at Work or a longer period if required by law.

Status Change: If You are an Employee, but no longer in an Eligible Class due to a reduction in the number of scheduled hours You work, Your insurance may be continued for up to 90 consecutive days after the date Your scheduled hours were reduced.

Disability: If You are an Employee receiving disability benefits under a long term disability benefit plan issued by Us to Your Employer, Your Life Insurance under the Policy will be continued for 12 consecutive months.

Reinstatement: If Your insurance ends because You are no longer employed by the Employer or no longer in Your Eligible Class then insurance for You may be reinstated, provided You request such reinstatement within 30 days of the date You return to work or to an Eligible Class.

The reinstated insurance will be the lesser of the:

1. insurance amounts in force on the date insurance ended; or
2. amount of insurance in Your new Eligible Class.

The reinstated insurance will:

1. not be subject to any Eligibility Waiting Period or Evidence of Insurability; and
2. be subject to all the other terms and provisions of the Policy.

We will credit any amount of time You were previously insured under the Policy toward the satisfaction of time limits under the Contestability provision of the Policy.

We will not reinstate any amount of insurance which You converted in accordance with the Conversion Right unless You cancel such insurance.

LIFE INSURANCE BENEFIT AND CONVERSION RIGHT

Life Insurance Benefit: If You die while insured under the Policy, We will pay the deceased person's Life Insurance Benefit Amount after We receive Proof of Claim. The benefit will be paid according to the Beneficiary provision.

Conversion Right: If the Life Insurance or any portion of it under the Policy ends, You may have the right to convert part or all of the terminated insurance to an individual policy without providing Evidence of Insurability. Conversion is not available for:

1. the Accidental Death and Dismemberment Benefits; or
2. any amount of Life Insurance for which You were not eligible and insured;

under the Policy.

If insurance ends because:

1. the Policy is terminated; or
2. insurance for an Eligible Class is terminated;

then You must have been insured under the Policy for 5 years or more, in order to be eligible to convert. The amount which may be converted under these circumstances is limited to the lesser of:

1. $10,000; or
2. the Life Insurance Benefit amount under the Policy less any amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life insurance.

If insurance under the Policy ends for any other reason, except non-payment of premium, the full amount of insurance which ended may be converted.

Conversion Process: To convert Your insurance, You must:

1. complete the required individual life conversion form;
2. have Your Employer sign the form; and
3. send the form to the Conversion Insurer at the address on the form.

The Conversion Insurer will verify Your eligibility and will send You a Conversion Policy proposal. You must:

1. complete and return the request form in the proposal; and
2. pay the required premium;

within 31 days of the date Your Life Insurance terminates.

Conversion Policy Provisions: The Conversion Policy will:

1. be issued on any one of the life insurance policy forms the Conversion Insurer is issuing for this purpose at the time of conversion; and
2. base premiums on the Conversion Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1. the same terms and conditions of insurance You had before converting;
2. any benefit other than life insurance; and
3. term insurance.

Conversion is not available for any amount of Life Insurance which is being continued according to:

1. the Waiver of Premium Benefit; or
2. the Continuation Provisions;

until such insurance ends.

Death within the Conversion Period: We will pay the deceased person's amount of Life Insurance You would have had the right to convert if:

1. You die within 31 days of the date insurance terminates; and
2. We receive Proof of Claim.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under the Policy for the amount converted.

Effect of Waiver of Premium on Conversion: If You apply and are approved for the Waiver of Premium Benefit after an individual Conversion Policy has been issued, any benefit payable at Your death under the Policy will be paid only if You cancel Your individual Conversion Policy. The Conversion Insurer will refund the premium paid for such Conversion Policy.

Conversion Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

WAIVER OF PREMIUM BENEFIT

Waiver of Premium: If You become Totally Disabled, We will continue Your Basic Life Insurance in force without premium payment while You remain Totally Disabled if:

1. Your Total Disability began before age 60;
2. You remain Totally Disabled continuously for at least 9 consecutive months; and
3. You give Us proof of Total Disability, as required.

We will:

1. waive Your premium payment, for Basic Life Insurance only, on a monthly basis, beginning the first day of the month after the month You become Totally Disabled; and
2. refund any premium paid for the Basic Life Insurance on and after that day.

We will not refund premiums for any period more than 12 months before the date proof of disability was furnished.

Waiver of Premium does not apply to any of the following benefits, in force at the time Your Waiver of Premium begins:

1. any Accidental Death and Dismemberment insurance;
2. any additional benefits under the Accidental Death and Dismemberment Insurance.

This Waiver of Premium will continue to be effective even if the Policy terminates after You become Totally Disabled.

Total Disability or Totally Disabled: For purposes of this benefit, You will be considered Totally Disabled if You are unable to perform each and every duty of:

1. Your occupation at Your usual place of employment; and
2. any job suited to Your education, training or experience.

If, for any reason, You are no longer Totally Disabled, and:

1. You return to Active Work in an Eligible Class, the insurance for which premiums have been waived will be reinstated, subject to the terms of the Policy that are in effect on the reinstatement date; or
2. You do not return to Active Work within an Eligible Class, and You are not eligible for any other group life insurance, You are entitled to convert the applicable insurance according to the Conversion Right. Any insurance for which premiums have not been waived and which has terminated will not be eligible for conversion.

Proof of Total Disability: You must give Us proof of Total Disability:

1. on forms We provide;
2. no later than 12 months after the date You became Totally Disabled; and
3. within 60 days after Our request.

We may require You to be examined, initially and periodically, at Our expense, by a Physician, other medical practitioner or Vocational Rehabilitation Consultant of Our choice. After You have been Totally Disabled for more than 2 years from the date of Total Disability, We will not request proof more than once a year.

Life Insurance Benefit Amount under the Waiver of Premium Benefit: The amount of Life Insurance continued will:

1. be the amount in force on the date You became Totally Disabled;

2. be subject to any age reductions or terminations shown in the Schedule of Benefits; and
3. not increase.

Death Benefit While Totally Disabled: If You die while insurance is being continued under this benefit, We will pay the death benefit if We receive proof that Total Disability was continuous from the date Total Disability began to the date of Your death.

Termination of the Waiver of Premium Benefit: You will no longer be eligible for the Waiver of Premium Benefit and Your Basic Life Insurance will terminate on the earliest of the following:

1. the date You cease to be Totally Disabled and do not return to Active Work;
2. the last day of the 60 day period following Our request for proof of Total Disability, if You do not give Us proof or refuse to take a medical exam;
3. the date You reach age 65; or
4. the date premium has been waived for 12 months and You have resided outside the United States for a total of 6 months or more during any 12 consecutive months for which premium has been waived.

ACCELERATED DEATH BENEFIT

Notice: The Accelerated Death Benefit payment may be taxable. You should seek assistance from Your personal tax advisor regarding taxes that may need to be paid as the result of claiming an Accelerated Death Benefit.

Accelerated Death Benefit: If while insured under the Policy, You become terminally ill, You may request an amount of Life Insurance be paid as an Accelerated Death Benefit. The request must be in writing and include written medical evidence signed by the treating Physician and acceptable to Us that You, as applicable:

1. are under a Physician's care for that condition;
2. have a life expectancy of less than 12 months; and
3. have agreed to a medical exam in connection with a claim, if requested.

To qualify for this benefit the terminally ill person must be insured for at least $10,000 of Life Insurance under the Policy. An Accelerated Death Benefit payment can only be made once in Your lifetime. You must continue to pay premium for the remaining amount of Life Insurance in force after the Accelerated Death Benefit has been paid.

The amount of the applicable Accelerated Death Benefit payable will not exceed:

1. the percentage of Your Life Insurance amount; and
2. the Accelerated Death Benefit Maximum Benefit Amount;

shown in the Schedule of Benefits.

The amount of Life Insurance payable upon the terminally ill person's death will be reduced by the Accelerated Death Benefit amount paid under this benefit.

Limitations: An Accelerated Death Benefit will not be payable if:

1. You have assigned Your Life Insurance Benefits;
2. We have been notified that all or a portion of Your Life Insurance Benefits are to be paid to Your former spouse as part of a divorce agreement;
3. You are required by law to accelerate benefits in order to meet the claims of creditor(s);
4. You are required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement; or
5. You are retired.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death and Dismemberment Benefit: If You sustain an Injury while insured under the Policy:

1. which results in any Loss as defined; and
2. within 365 days of an Accident;

We will pay for that Loss by applying the percentage shown in the Loss Table to the Benefit Amount shown in the Schedule of Benefits.

Accident/Accidental means an unforeseen event that:

1. occurs suddenly as a result of an external circumstance or trauma;
2. has specific identifiable components, including date and time; and
3. results in Injury to the physical structure of the body or death or dismemberment.

Loss Table:

Loss of Life	100%
Loss of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	50%
Loss of one hand	50%
Loss of one foot	50%
Loss of sight of one eye	50%
Loss of speech	25%
Loss of hearing	25%
Hemiplegia	50%

Loss means:

1. Loss of life: caused by an Accident.
2. Loss of hands or feet: severance at or above the wrist or ankle.
3. Loss of sight: total and irrecoverable loss of sight.
4. Quadriplegia: total and permanent Paralysis of both upper and lower limbs.

5. Paraplegia: total and permanent Paralysis of both lower limbs.
6. Loss of speech: the total and irrecoverable loss of speech.
7. Loss of hearing: total and irrecoverable loss of hearing.
8. Hemiplegia: total and permanent Paralysis of upper and lower limbs on one side of the body.

Paralysis means the permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb.

Exposure and Disappearance:

Exposure to the elements will be presumed to be an Injury if:

1. it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant at the time of the Accident; and
2. the Policy would have covered an Injury resulting from the Accident.

We will presume that You suffered Loss of life if:

1. the person's body has not been found within one year after the disappearance of a conveyance in which You were an occupant at the time of its disappearance;
2. the disappearance of the conveyance was due to its Accidental forced landing, stranding, sinking or wrecking; and
3. the Policy would have covered Injury resulting from the Accident.

We will not pay more than the Benefit Amount shown in the Schedule of Benefits for losses resulting from any one Injury.

SEAT BELT AND AIRBAG BENEFIT

Seat Belt Benefit: If You die from an Injury that results in the payment of a Loss of life benefit under the Accidental Death and Dismemberment Benefit, We will pay a Seat Belt Benefit if the Injury occurred while the deceased was:

1. a passenger riding in; or
2. the licensed operator of;

a Motor Vehicle and was wearing a Seat Belt at the time of the Accident, as verified on the police accident report.

This benefit is not payable if, at the time of the Accident, the driver of the Motor Vehicle:

1. was legally Intoxicated;
2. was taking drugs, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician; or
3. did not hold a valid driver's license.

Airbag Benefit: If a Seat Belt Benefit is payable, We will also pay an Airbag Benefit if the deceased was positioned in a seat equipped with a factory-installed Airbag.

The benefit payable:

1. will be paid in addition to the Accidental Death and Dismemberment Loss of life benefit; and
2. is shown in the Schedule of Benefits.

Airbag means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Airbag is not considered a Seat Belt.

Common Carrier means a conveyance operated by a business, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that business. Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

Motor Vehicle means a self-propelled, four (4) or more wheeled conveyance not being used as a Common Carrier. A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

Seat Belt means:

1. an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle;
2. proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications; or
3. a child restraint device that meets the standards of the National Safety Council and is properly secured and used in accordance with applicable state law and installed according to the recommendations of its manufacturer.

The investigating officer must certify the correct position of the Seat Belt or child restraint device. A copy of the police accident report must be submitted with the claim.

EXCLUSIONS AND LIMITATIONS

Accidental Death and Dismemberment Exclusions: We will not pay a benefit for a loss contributed to or caused by:

1. disease, bodily or mental infirmity, or medical or surgical Treatment for such conditions;
2. suicide or intentionally self-inflicted Injury;
3. active participation in a riot;
4. committing or attempting to commit a crime, or participating or attempting to participate in a crime;
5. taking part in the commission of an assault or being engaged in an illegal activity;
6. an act or Accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
7. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for You by a Physician and taken as prescribed;
8. an Injury while Intoxicated;
9. driving or in physical control of a Motor Vehicle while Intoxicated;
10. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping or using off-road vehicles;
11. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which You are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule. NOTE: This coverage under this certificate is not to be construed to provide benefits required by Worker's Compensation laws.
12. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

CLAIM INFORMATION

All benefits payable under the Policy will be paid according to the following provisions.

Notice of Claim: You, the person who has the right to claim benefits or Your authorized representative, must give Us, written notice of a claim, at Our Home Office, within 30 days after:

1. the date of death; or
2. the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

The claim form is available from Your Employer, or can be requested from Us. If the form is not received from Us within 15 days of a request, written Proof of Claim should be sent to Us without waiting for the form. Written proof must fully describe the nature and extent of the claim.

Proof of Claim: Written Proof of Claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of Claim may include the following:

1. a completed claim form;
2. a certified copy of the death certificate (if applicable);
3. Your enrollment form;
4. Your Beneficiary designation (if applicable);
5. documentation of:
    a. the date Your disability began;
    b. the cause of Your disability; and
    c. the prognosis of Your disability;
6. all medical information, including reports of diagnostic testing and photocopies of medical records, including histories;
7. physical, mental or diagnostic examinations and treatment notes;
8. the names and addresses of all:
    a. Physicians or other qualified medical professionals You have consulted;
    b. hospitals or other medical facilities in which You have been treated; and
    c. pharmacies which have filled Your prescriptions within the past three years;
9. Your signed authorization for Us to obtain and release medical, employment, and financial information (if applicable);
10. documentation of Your hours worked, earnings and all other types of income;
11. proof of any Employer approved Leave of Absence; or
12. any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

You and Your Employer must fill out the applicable designated section of the claim form and then give it to Your attending Physician. The Physician should fill out their section of the form and send it directly to Us.

We may request that You provide proof of continuing disability, satisfactory to Us, indicating that You are under the regular care of a Physician. The proof, provided at Your expense, must be received within 30 days of a request by Us.

In some cases, You will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of Your Proof of Claim, or proof of continuing disability. We will deny Your claim or stop making Your payments if the appropriate information is not submitted.

You must notify Us immediately when You return to work in any capacity.

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the Beneficiary provision. All other benefits under the Policy are paid to You.

Time of Claim Payment: We will pay a claim for loss of life after We receive due Proof of Claim. However, if special circumstances require an extension, We will provide You or Your authorized representative with:

1. a description of any further proof needed to complete the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim.

Legal Action: You may not bring suit to recover under this section until 60 days after You have given Us written Proof of Claim. No suit may be brought more than three years after the date of loss.

Beneficiary means the person(s) You name in writing to receive any amount of insurance payable due to Your death. You may name or change a Beneficiary by giving written notice to Us. The Beneficiary notice will be effective on the date made, subject to any payment We may have made before the notice was received. For Beneficiary notices, Administrator means the Employer.

If You name more than one Beneficiary, those who survive will share equally unless You specify otherwise. If there is no named Beneficiary living at the time of Your death, We will pay any amount due in the following order:

1. to Your legal spouse or Your domestic partner;
2. to Your natural or legally adopted children in equal shares;
3. to Your parents;
4. to Your brothers and sisters; or
5. to Your estate.

If Your named primary beneficiaries die before You, their share will be payable in equal shares to any other named primary beneficiaries who survive You. If You have named a contingent beneficiary, the contingent beneficiary will only be paid if all primary beneficiaries die before You. If You have not named a primary or contingent beneficiary, or if all the person(s) You have named as primary or contingent beneficiaries die before You, payment will be made as follows:

1. to Your legal spouse or domestic partner, if any;
2. if there is no spouse or domestic partner, in equal shares to Your children;
3. if there is no spouse; or domestic partner or children, to Your parents, equally or to the survivor;
4. if there is no spouse; domestic partner, children, or parents, in equal shares to Your brothers and sisters; or
5. if none of the above survives, to Your executors or administrators.

Assignment: Your Life Insurance as provided by the Policy may be assigned as an absolute assignment only. In making an assignment, You must transfer all Your present and future ownership rights to the person to whom You assigned the insurance. This includes the right to change the Beneficiary and to convert the insurance. You may not make a collateral or partial assignment of Your insurance. Accidental Death and Dismemberment Benefits provided by the Policy cannot be assigned.

Physical Examination and Autopsy: We have the right to have You examined by a Physician of Our choice as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Settlement Options: Instead of a single payment, You may choose another settlement option We may have available. We will give You full information about that option upon request. If You have chosen a settlement option, no one may change it unless You consent in writing. Your Beneficiary may only choose a settlement option within 60 days after Your death if one has not been chosen.

Overpayment of Claim: We have the right to recover any overpayments due to fraud or any error We make in processing a claim. You must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from Your Beneficiary.

Conformity with State or Federal Statutes: If any provision of Your Certificate conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

Rights of Authority: When making a benefit determination under the Policy, We have the sole discretionary authority:

1. to determine Your eligibility, if applicable, for benefits;
2. to interpret the terms, conditions, limitations, and exclusions of the Policy; and
3. to interpret all other provisions of the Policy including the Certificate and any riders, endorsements or amendments.

We may delegate this discretionary authority to other entities or persons who provide services in regard to the administration of the Policy.

This provision applies, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

This provision:

1. does not prevent Your rights to bring legal action as stated in the Legal Action provision; and
2. does not serve to deprive any insurance department of its statutory rights and obligations.

Fraud: We will use all means necessary to support fraud detection, investigation, and prosecution. Submission of false or misleading information may result in denial of Your claim, and may be subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Contestability: We may not contest the validity of Your insurance, except for the non-payment of premiums, after it has been in force for two years from its date of issue. Statements made in any signed application relating to such insurability will not be used to contest the validity of the insurance after such insurance has been in force for two years from its date of issue. In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. This clause will not affect Our right to contest claims made under the Accidental Death and Accidental Dismemberment Benefits.

Misstatement of Age: If Your age has been misstated, premiums will be adjusted. If the amount of the benefit is based on age, the benefit will be adjusted based upon Your correct age.

Workers' Compensation: The Policy does not provide benefits required by any Workers' Compensation laws.

REPATRIATION BENEFIT – LIFE

Repatriation Benefit: If You sustain an Injury that results in death, We will pay a lump sum Repatriation Benefit, if:

1. Your death occurs:
    a. more than 100 miles from; and
    b. outside the territorial limits of the state or country of;

    the deceased person's permanent place of residence; and
2. expenses are incurred for the preparation and transportation of the deceased person's body to a mortuary near the deceased's permanent place of residence.

The benefit payable is the lesser of:

1. actual expenses incurred; or
2. the amount shown in the Schedule of Benefits.

The benefit is payable to the person who incurs the expenses. This benefit is paid in addition to any other benefits provided under the policy.

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to 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.

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. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 you the materials and pay you up to $110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. 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 costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

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, contact the nearest Area Office of the Employee Benefits Security Administration, United States 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.

CLAIMS DENIAL FOR LIFE INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 90 days following the receipt of the claim or within 90 days following the expiration of the initial 90 day period, in a

case where there are special circumstances requiring extension of time for processing the claim. If special circumstan-ces require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 90 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial; 2) reference to the provision(s) of the Plan on which the denial is based; 3) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; and 4) an explanation of the claim review procedure. If written notice of the denial is not furnished to the claimant within 90 days (or if an extension was required, 180 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR LIFE INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier’s service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 60 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 60 day period, but no later than 120 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 60 day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the final written decision is not furnished to the complainant within 60 days (or if an extension was required, 120 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.