



PURCHASING DEPARTMENT  
1772 County Services Parkway  
Marietta, Georgia 30008-4012  
(770) 528-8400/FAX (770) 528-1154

Rick Brun  
DIRECTOR

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**ADDENDUM No. 3**  
**Sealed Bid # 10-5490**  
**Request for Proposal**  
**Long Term Disability Insurance and Life/AD&D Insurance**  
**DATE: May 14, 2010**

The following addendum hereby amends and/or modifies the Proposal Documents and specifications as originally issued for this project. All proposers are subject to the provisions of this Addendum.

**Proposers shall acknowledge receipt of this addendum.**

Include this original form inside your proposal package.

**This Addendum consists of:**

- Minutes of the May 10, 2010 Pre-Proposal Conference and attachments
- Questions submitted in writing
- Pre-Proposal Meeting Attendee List
- Attachment 1– Aetna Employer Application
- Attachment 2– Metlife Application for Group Insurance
- Attachment 3– Aetna Long Term Disability Booklet
- Attachment 4– Metlife Certificate of Insurance
- Attachment 5– Active Judges Life

All bids must be received before 12:00 (noon) by the Bid Opening date. Bids shall be delivered to Cobb County Purchasing Department, 1772 County Services Parkway, Marietta, GA 30008.

Electronic / faxed bid response will not be considered.

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I acknowledge that I have received Addendum No. 3

**Sealed Bid # 10-5490**  
**Request for Proposal**  
**Long Term Disability Insurance and Life/AD&D Insurance**

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Sent to Purchasing

\_\_\_\_\_  
Please Print Name

Please sign, date, and return this form ONLY to:  
Cobb County Purchasing Department  
Fax #: 770-528-1154  
E-Mail: [purchasing@cobbcounty.org](mailto:purchasing@cobbcounty.org)

Please note: The deadline for questions is: Tuesday May 18, 2010 by 5:00 pm  
Any questions received after this deadline will not be considered.

Addendum 3  
Cobb County Sealed Bid # 10 – 5490  
Long Term Disability Insurance and Life AD&D Insurance

Pre-Proposal Conference  
Monday, May 10, 2010 – 10:00 a.m. (E.S.T.)  
Cobb County Commission Board Room  
100 Cherokee Street 2<sup>nd</sup> Floor  
Marietta, GA 30090

**Question:** Are bids expected to match current options for Basic Life and AD&D and Long Term Disability?

**Answer:** Yes, the proposal should match the current options.

**Question:** If my company does not provide the additional services for flexible spending administration and enrollment services should I partner with a broker to provide these services?

**Answer:** Currently, the incumbent brokers have partnered to provide these services to the County.

**Question:** Who is the incumbent broker(s)?

**Answer:** Houze and Assoc. of LaGrange, Georgia and The Deaton Group of Macon, Georgia

**Question:** The Group Term Life Insurance product does not appear to have a maximum limitation, is that correct?

**Answer:** There is currently no limitation on the Group Term Life benefits as it provides two times base salary without any maximum limitation. After reviewing current salaries of county employees and administrators, we would be comfortable with quotes assuming a combined Basic + Supplemental maximum life insurance benefit of \$1,000,000 .

**Question:** How is the optional “buy-up” premium determined?

**Answer:** The employee premium for 1 X salary benefit under the Group Term Life policy is age banded, the rates are provided on the attached renewal letter from MetLife dated August 16, 2007.

(See MetLife Contract)

LTD Benefits

60% Plan per \$100 CMP \$0.360 {100% Employer paid}  
10% Buy up per \$100 CMP \$0.220 {100% Employee paid}

(See Aetna Contract)

**Question:** Please clarify the volume for the optional “buy-up” life benefit.

**Answer:** The census was provided with the salary information, the volume is 1 x base pay for those electing this coverage.

**Question:** Can copies of the Group Life and LTD contracts be provided?

**Answer:** Attached please find copies of the MetLife Application for Group Insurance and Aetna's Master Employer Application.

**Question:** Can one or two companies provide the insurance coverage?

**Answer:** Yes, if that is deemed to be best for the County. Currently two different companies provide the services, MetLife for Group Term Life and Aetna for Long Term Disability benefits.

**Question:** Would the County consider other options beyond the 2X Group Life coverage?

**Answer:** The bid responses should match what is currently being provided. If you wish to add other options you may do so.

**Question:** What are the current broker commissions included for Life/AD&D and LTD?

**Answer:** 8%

**Question:** Will you please provide the current age banded voluntary life rates?

**Answer:** Provided with the Contract Documents.

**Question:** Can you please explain how the current buy up LTD premiums are calculated?

**Answer:** The 10% buy-up coverage (additional premium paid by approximately 1222 members) is calculated based upon the gross pay x .0022.

EXAMPLE: One individual's bi-weekly gross earnings: \$2,732.35 x .0022 = \$6.01 bi-weekly premium

**Question:** Does Cobb County BOC participate in Social Security? If yes does this apply to all or a portion of the group, please specify?

**Answer:** Cobb County Government participates in Social Security and Medicare benefit programs for all employees. (Note: the Superior Court Judges County Supplemental Pay is subject to Medicare only.

**Question:** Can you please provide a copy of the current policy for long term disability?

**Answer:** Policy was previously provided

**Question:** The cert we received included a child care benefit, but this is not included on the renewal summary. Is this still included in the plan?

**Answer:** The Child Care benefit is part of the current LTD policy. Please submit the proposal to include all benefits currently covered under the existing plan, if there is some reason you are not able to match the current provision, please indicate why.

**Question:** The renewal includes the core and the buy-up information separately as well as combined. Is this required? Or is only a combined experience exhibit acceptable?

**Answer:** The selected LTD Carrier will need to provide experience broken out by Core and Buy-up, separately.

**Question** Please provide the inforce life rates and rate history.

**Answer:** Rates are provided in the Contract Documents.

**Question:** Are commissions needed in the rates?

**Answer:** The rates currently include a 8% commission for LTD rates. If you choose to submit through a broker we expect you would mutually decide on the level of commission to include.

**Question:** Does the Life coverage have a maximum benefit? RFP states the Life coverage does not have a maximum. However, the life contract states a combined maximum of 2.5M.

**Answer:** Combined \$1,000,000

**Question:** Please provide the prior effective dates and carriers if you have them.

**Answer:** MetLife provides the Group Term Life benefits and Aetna provides the Group LTD benefits since 5/1/2005 to present, both contracts will expire on June 30, 2010. Prior to this, UnumProvident was the carrier for both the Group Term Life and Long Term Disability contracts

**Question:** Who handles the County's life administration?

**Answer:** MetLife is the carrier, general plan administration is handled by County's HR staff.

**Question:** Within the questionnaire page R-6- Questions 18-22 reference Flexible Spending Account. This would not apply to Life and Disability. Was this listed in error ?

**Answer:** The current arrangement provide by the Broker provides administrative services for FSA Accounts.

**Question:** What is the Life Insurance value for Judges?

**Answer:** Judges receive salary from the State and from the County, the life figures are manually updated annually. Attached is a listing of up-dated amounts, as of January 1, 2010.

The MetLife contract does not specifically address this issue, but they have acknowledged that claims will be paid accordingly. There are three Senior Judges who have a covered benefit for 1 x salary at the value when they left the bench.

Values: \$106,683.87, \$50,000; \$156,000

**(See attached listing)**

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Values: \$106,683.87, \$50,000; \$156,000

**(See attached listing)**

PRE- BID CONFERENCE

REQUEST FOR PROPOSAL  
 LONG TERM DISABILITY INSURANCE AND LIFE/AD&D INSURANCE  
 SEALED BID #10-5490  
 COBB COUNTY HUMAN RESOURCES DEPARTMENT  
 MAY 10, 2010

| REPRESENTATIVE NAME | COMPANY NAME & COMPLETE ADDRESS  | PHONE (INCLUDE AREA CODE) | FAX # (INCLUDE AREA CODE) | E-MAIL ADDRESS                                      |
|---------------------|--|---------------------------|---------------------------|---|
| ✓ Ray Shaffer       | HARTFORD Life<br>1125 Suncourt Pkwy Ste 450<br>Alpharetta, GA 30004    | 678-566-4416              | 770-475<br>1404           | ray.shaffer@hartfordlife.com                        |
| ✓ Mike Otis         | ING Employee Benefits<br>5780 Powers Ferry Rd. NW<br>Atlanta, GA 30328 | 770-541-3118              | 770-541-3130              | Michael.Otis@usins.com                              |
| ✓ Dave Douglas      | SunLife Financial<br>1100 Abernethy Rd, Atlanta, GA 30329              | 770-512-0091              | 770-512-0091              | david.douglas@sunlife.com                           |
| ✓ Ron Wittmann      | PRUDENTIAL<br>2 REVINIA DR (1650)<br>ATLANTA GA 30346                  | 770-604<br>7335           | 770-604-7336              | <del>RONALD</del><br>RONALD.WITTMANN@PRUDENTIAL.COM |
| ✓ Ron Kjar          | BOBSGA<br>3350 Peachtree Rd<br>Atlanta, GA 30326                       | 404-842-8511              | 404-842-8460              | rkjar@bobsga.com                                    |
| ✓ Linda Reid        | Aetna<br>11675 Great Oaks Way<br>Alpharetta, GA 30022                  | 770-346-1267              | 800-975-1514              | ReidLI@Aetna.com                                    |
| Tommy Feiler        | Cobb County HR   | 2564                      |                           |   |
| Don Hays            | Cobb City  |                           |                           |   |

PRE- BID CONFERENCE

REQUEST FOR PROPOSAL  
 LONG TERM DISABILITY INSURANCE AND LIFE/AD&D INSURANCE  
 SEALED BID #10-5490  
 COBB COUNTY HUMAN RESOURCES DEPARTMENT  
 MAY 10, 2010

| REPRESENTATIVE NAME | COMPANY NAME & COMPLETE ADDRESS                                 | PHONE (INCLUDE AREA CODE) | FAX # (INCLUDE AREA CODE) | E-MAIL ADDRESS               |
|---------------------|---|---------------------------|---------------------------|------------------------------|
| ✓ Bill Houze        | Houze & Assoc.<br>308 Church St.<br>La Grange GA 30241          | 706-882-2864              | 706-883-6651              | billhouze@houze.oxg          |
| ✓ Dan Piacentini    | Blue Cross + Blue Shield of GA<br>Greater Georgia Life          | 404 923 3241              | 404 923 3215              | daniel.piacentini@authon.com |
| ✓ Elson Gray        | <del>Associated Insurers</del>                                  | <del>205 871 5500</del>   | 205 254 9080              | gray@elbenefits.com          |
| ✓ BERNICE FRANKLIN  | THE HARWEN GROUP<br>3040 HIGHLANDS PLUG. #A<br>SMYRNA, GA 30082 | 770 432-5620              | 770 4341638               | HARWEN GRP@AOL.COM           |
| ✓ Megan Frey        | ING Employee Benefits<br>5780 Powers Ferry Rd Atlanta 30327     | 770-541-3104              | 770-541-3130              | Megan.frey@us.ing.com        |
| ✓ MICHAEL GARZA     | Aetna<br>11675 Great Oaks Way<br>Alpharetta, Ga 30022           | 770 346 2424              | 800-975-1516              | GARZAMR@aetna.com            |
| TRACY MINJAUW       | Cobb County   |                           |                           |                              |
| Chris Clark         | The M&E Grp   |                           |                           |                              |



# Employer Application

**Applicant**

Policy or Group Number  
(for Aetna use only)

885645

Company Name: Cobb County Government

Street Address: 100 Cherokee Street, Suite 350

City: Marietta State: GA Zip Code: 30090-9679

Federal Tax ID Number: \_\_\_\_\_

Parent Company name (if applicable) \_\_\_\_\_

The purpose of the application is to request:

- a.  issuance of new coverage
- b.  change in existing coverage
- c.  extension of existing coverage to additional groups of employees

**Medical Coverage Selection:** Provided or administered by Aetna Health Inc., Aetna Life Insurance Company, Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company of Connecticut, and/or Corporate Health Insurance Company.

|                  | For Employees            | For Dependents           | For Retirees             | Type of Coverage |
|------------------|--------------------------|--------------------------|--------------------------|------------------|
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medical          |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |

**Stand-Alone Dental Coverage Selection:** Provided or administered by Aetna Health Inc., Aetna Dental Inc., Aetna Dental of California Inc., Aetna Insurance Company of Connecticut, and/or Aetna Life Insurance Company.

|                  | For Employees            | For Dependents           | For Retirees             | Type of Coverage |
|------------------|--------------------------|--------------------------|--------------------------|------------------|
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental Coverage  |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |

**Life, Disability, and Long Term Care:** Provided or Administered by Aetna Life Insurance Company

|                  | For Employees            | For Dependents           | For Retirees             | Type of Coverage   |
|------------------|--------------------------|--------------------------|--------------------------|--|
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Basic Term Life Insurance<br>Dependents' Maximum subject to state law        |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Supplemental Term Life Insurance<br>Dependents' Maximum subject to state law |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | Not Available            | Accidental Death & Personal Loss Coverage                                    |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | Available                |  |
| Contributory     | <input type="checkbox"/> | <input type="checkbox"/> | Not Available            | Supplemental Accidental Death & Personal Loss Coverage                       |
| Non-Contributory | <input type="checkbox"/> | <input type="checkbox"/> | Available                |  |

**Attachement 1**

|                  |                                     |                          |  |                          |                       |
|------------------|-------------------------------------|--------------------------|--|--------------------------|-----------------------|
| Contributory     | <input checked="" type="checkbox"/> | Not                      |  | Not                      | Long Term Disability  |
| Non-Contributory | <input checked="" type="checkbox"/> | Available                |  | Available                |                       |
| Contributory     | <input type="checkbox"/>            | Not                      |  | Not                      | Short Term Disability |
| Non-Contributory | <input type="checkbox"/>            | Available                |  | Available                |                       |
| Contributory     | <input type="checkbox"/>            | <input type="checkbox"/> |  | <input type="checkbox"/> | Long Term Care        |
| Non-Contributory | <input type="checkbox"/>            | <input type="checkbox"/> |  | <input type="checkbox"/> |                       |
| Contributory     | <input type="checkbox"/>            | <input type="checkbox"/> |  | <input type="checkbox"/> | Other: _____          |
| Non-Contributory | <input type="checkbox"/>            | <input type="checkbox"/> |  | <input type="checkbox"/> |                       |

**General enrollment and eligibility section**

Requested effective date: 05/01/2005 (Actual effective date will be assigned by Aetna if the application is accepted and a policy issued.)

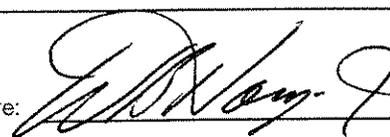
Applicant will utilize electronic enrollment (check one):  Yes  No

This application includes the following member employers.  
 (Any entry in conflict with applicable law cannot be included): Additional sheets may be added if necessary.  
**\*\*refer to the installation checklist\*\***

|  |            |  |
|--|------------|--|
|  | Located At |  |
|  | Located At |  |
|  | Located At |  |

All of the regular, full-time active employees of any employer mentioned above shall be eligible to participate as to the coverage hereby applied for, except the following (state here, by coverage, the class or classes excluded). If more space is needed, please attach an additional sheet.

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Agent(s) of Record: Houze & Associates/ Group Insurance Associates  
 Name: Bill Houze/Charlie Deaton Signature:  License #: 114275

**Applicant Acknowledgements and Agreements**

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. With the exception of Arizona (refer to group applicant paragraph below), it is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically agreed to by Aetna and provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected the coverage specified herein based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Policy and/or Group Agreement available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Policy and/or Group Agreement.

Applicant has selected, in accordance with applicable state law, the coverage to be offered to Applicant's employees and Applicant has solely determined any/all coverage options for the Applicant's employees and the contribution amounts.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage. (Does not apply to Applicants in Illinois, Kansas and Missouri). See below for applicable provisions.

## Attachement 1

### Applicant Acknowledgements and Agreements (Continued)

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

Applicant agrees to deliver or otherwise make available to enrollees all Aetna paper or on-line member documents and other plan related materials upon request by Aetna.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement and/or Group Policy is in force. The availability of a plan or program may vary by geographic service area.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

**ARIZONA GROUP APPLICANTS:** Eligibility requirements for active employees will be determined by the employer as stated in the Terms and Charges of the proposal. The information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Arizona law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

**KANSAS, ILLINOIS & MISSOURI GROUP APPLICANTS:** The Group Agreement and/or Group Policy will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the form. Any direct conflict between this form and the Group Agreement will be resolved according to the terms which are most favorable to the member.

### Important Information

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 may have violated state law.

**ARIZONA HMO APPLICANTS:** I understand that if it is determined that I have committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, my company's group health coverage may be terminated or my company may be charged a different premium for this coverage.

**COLORADO GROUP APPLICANTS:** Please see the Colorado Disclosures attachment.

**KENTUCKY, OHIO & PENNSYLVANIA CONTRACT SITUS:** 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.

**MAINE CONTRACT SITUS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NEW YORK CONTRACT SITUS:** As to Accident and Health insurance coverage, 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim of each such violation.

**OHIO HMO APPLICANTS:** Any Group may cancel a signed agreement within seventy-two hours after having signed the agreement to enroll under this plan. Cancellation occurs when written notice of the cancellation is given to the HMO or its agents or other representatives. A notice of cancellation mailed to the HMO shall be considered to have been filed on its postmark date.

**TENNESSEE HMO APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**Important Information (Continued)**

**WASHINGTON CONTRACT SITUS:** Enrollees who cannot provide proof of prior Creditable Coverage may be subject to pre-existing conditions limitations or exclusions with no credit for prior Creditable Coverage. Enrollees may request a Certificate of Creditable Coverage from their prior carrier. Acceptable forms of proof of prior Creditable Coverage are: a Certificate of Creditable Coverage from the prior carrier; a copy of an ID card or the most recent payroll stub showing medical coverage deduction; or a copy of the most recent medical premium bill from the prior carrier.

Creditable Coverage is coverage of the Member under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (TRICARE), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. Credible Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided by a separate policy.

In Washington, the HMO product is named Primary Choice and offered by Aetna Health Inc., a licensed Health Care Services Contractor.

**CALIFORNIA HMO APPLICANTS:** Any dispute arising from or related to the Group Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further information.

The undersigned representative of the Employer understands that the Employer and any Groups eligible through the Employer, if different from the Employer, and any Members who enroll under this health plan are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that the Employer, Groups, Members and other interested parties will not be able to try their case in court. The undersigned representative of the Employer further understands and accepts that the Employer, Groups and Members are giving up certain remedies and that there may be certain limitations to the recovery of punitive damages.

**Signature Section**

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete. I understand that this application will form a part of the Group Agreement and/or Group Policy issued by Aetna and by my signature below I agree to be bound by the terms and conditions of that Group Agreement and/or Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any state requirements.

Signed at (location):  Marietta, GA   
City, State

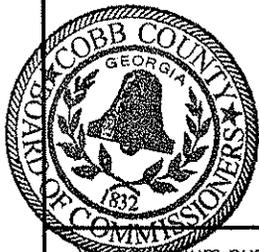
Cobb County Government   
Applicant (Company Name)

By:  [Signature]   
Authorized Applicant Signature

Samuel S. Olens   
Chairman, Cobb County Board of Commissioners  
Official Title

Candace W. Ellison   
Witness

4-28-05   
Date



Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-licensed independent agent or broker identified in the Application for Group Coverage. We appreciate your business and the opportunity to serve you.

**APPROVED**  
PER MINUTES OF  
COBB COUNTY  
BOARD OF COMMISSIONERS  
 3-22-05

**Employee Contribution Percent towards disability coverage:**

Pre-Tax Basis (employee contribution): \_\_\_\_\_ %  
[Used to determine the taxable portion of the benefit]

Post-Tax Basis (employee contribution): \_\_\_\_\_ %  
[List percent for each coverage, e.g.: Short or Long Term and if different for each control-suffix account number.]

Employer: Cobb County Government Aetna Life Insurance Company

[Plan Sponsor]

Signature of Authorized Representative: [Signature]  
Title: Chairman, Board of Commissioners  
Date: 4-28-05

Signature of Authorized Representative: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_



Please return completed agreement to:

Aetna Life Insurance Company  
Attn: Tax Reporting Unit - 5287  
PO Box 2883  
Hartford, CT 06101-8785

Any questions can be directed to the Aetna Tax Reporting Unit at (860) 636-3100.

**References:**

- § 6051 (f)(1) - Reporting by third parties
- § 31.6051-3 Detail reports to PAYER from Payer
- § 121(a) & 32.1(e)(3) - FICA
- § 1.402(a)-1 - Voluntary Income Tax Withholding on Insured Plans
- 31.3401 (a)-1(b)(8) - Mandatory Income Tax Withholding on Non Insured Plans as agent
- § 3504 - Acts of an Agent
- Rev. Ruling 2004-55 [EE basis]
- IRS Pub. 15A
- IRS Notice 91-26

Substitute Form 2678, NB 139

Dated: June 21, 2004 Ver:2

Attachement 1

Aetna Life Insurance Company  
"Aetna"  
AGENCY AGREEMENT  
Sick Pay

Based on the Plan Sponsor's determination of the taxable portion of the benefit Aetna as the payer will be responsible for the following functions effective for Tax Years on or after: 5/1/2005.

**Employee Income Tax Withholding** – Aetna would be responsible to deduct and remit Federal Income Tax withholding. [Withheld amounts will be remitted using the Aetna Name, Address, and Employer Identification Number (EIN): 06-6033492]

**Employee FICA Deductions** – Aetna would be responsible to deduct and remit the Employee ("EE") FICA withholding. [Withheld amounts will be remitted using the Aetna Name, Address, and EIN]

**FUTA/SUTA** – Aetna passes back to the Plan Sponsor any Federal Unemployment Tax (FUTA) and any State Unemployment Tax (SUTA) depositing and reporting responsibilities. Aetna cannot assume responsibility for the types of deposits of these funds.

Please check the following items you direct Aetna to administer on your behalf:  
Check appropriate box:

**Tax Reporting** – Aetna will be responsible to issue Form W-2 to individual sick pay recipients [Forms would be issued under the Aetna Name, Address, and EIN]

**EE & Employer ("ER") FICA Payments** - Aetna would be responsible to deduct and remit the EE FICA withholding and the ER matching share based on a reimbursement agreement between the Plan Sponsor and Aetna. If you would like to pursue this arrangement, please contact us for more information on the required approval steps and current charge amount. [Forms W-2s and deposits will be done under the Aetna Name, Address, and EIN]

**Tax Reporting** – Plan Sponsor will be responsible to issue the Form W-2 to individual sick pay recipients and remit the ER FICA share based on the information provided by Aetna. [Form W-2s and deposits would be done under the Policyholder/Employer's Name, Address, and EIN]

**Note:**

**Wisconsin** requires Aetna as a third-party payer of sick pay benefits to retain the recipient and state reporting obligations for Wisconsin source income.

Plan Sponsor Name: Cobb County Government  
Employer Name: Cobb County Government  
Contact Name: TRACY MINZAU Phone Number: 770 528-2542  
Plan Sponsor Address: 100 Cherokee Street  
Suite 350  
MARIETTA, GA 30090-9679

[Address where Aetna reports should be sent. If more than one, please attach list to this form. Refer to the "Sick Pay Booklet" for more detailed information about Aetna's reports.]

Employer Identification Number (EIN): 58 - 6000804

[If more than one, click here](#)

Aetna Control #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(6 digit) Control # (2 digit) Suffix # (3 digit) Account #

**APPROVED**  
PER MINUTES OF  
COBB COUNTY  
BOARD OF COMMISSIONERS  
3-22-05

13. CONSENT AGENDA ITEMS APPROVED (CONT.):

COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) (CONT.)

13SS. APPROVAL OF A THREE-YEAR CONSORTIUM AGREEMENT FOR THE GEORGIA URBAN COUNTY CONSORTIUM UNDER THE HOME PROGRAM – COMMUNITY DEVELOPMENT BLOCK GRANT:

To approve a Consortium Agreement with the U. S. Department of Housing and Urban Development (HUD) for continued participation in the current HOME Program Consortium, Georgia Urban County Consortium, (GUCC) for a three-year period from January 1, 2006 to December 31, 2008, with an automatic renewal at the end of each HUD three-year qualification period, unless changes in the Agreement are required by HUD, or if Cobb County or any of the other two (2) jurisdictions choose to terminate its participation in the GUCC.

FINANCE

13TT. ADOPTION OF RESOLUTION AUTHORIZING THE ISSUANCE OF "COBB COUNTY, GEORGIA GENERAL OBLIGATION PARK AND RECREATION REFUNDING BONDS, SERIES 2005" TO ADVANCE REFUND, DEFEASE AND OPTIONALLY REDEEM (OR PAY AT MATURITY, AS APPLICABLE) THE COUNTY'S OUTSTANDING "GENERAL OBLIGATION PARK AND RECREATION BONDS, SERIES 1996" MATURING ON OR AFTER JANUARY 1, 2008 – FINANCE:

To adopt a resolution authorizing the issuance of not to exceed \$19,500,000.00 in original aggregate principal amount of "Cobb County, Georgia General Obligation Park and Recreation Refunding Bonds, Series 2005" (the "2005 Bonds") to advance refund, defease and optionally redeem (or pay at maturity, as applicable) the county's outstanding General Obligation Park and Recreation Bonds, Series 1996 (the "1996 Bonds") maturing on or after January 1, 2008 (collectively, the "Refunded Bonds" or the "Series 1996 Refunded Bonds") outstanding in the aggregate principal amount of \$18,515,000.00 and paying the costs of issuance of the Series 2005 Bonds.

Funding: No allocation of additional funds is required. As approved by the Board of Commissioners at their meeting no March 8, 2005, issuance costs will be paid from 2005 Bond proceeds and ongoing bond administration costs will be budgeted.

HUMAN RESOURCES

13UU. APPROVAL OF A THREE-YEAR CONTRACT WITH AETNA LIFE INSURANCE COMPANY FOR GROUP LONG TERM DISABILITY (LTD) INSURANCE BENEFITS, AND APPROVAL OF A THREE-YEAR CONTRACT WITH METLIFE INSURANCE COMPANY FOR GROUP TERM LIFE INSURANCE – HUMAN RESOURCES:

To approve a three-year contract with Aetna Life Insurance Company for Group Long Term Disability (LTD) insurance benefits, approve a three-year contract with MetLife Insurance Company for Group Term Life insurance benefits, for the term May 1, 2005 through April 30, 2008, and authorize the Chairman to execute the necessary documents.

13. CONSENT AGENDA ITEMS APPROVED (CONT.):

HUMAN RESOURCES (CONT.)

13UU. APPROVAL OF A THREE-YEAR CONTRACT WITH AETNA LIFE INSURANCE COMPANY FOR GROUP LONG TERM DISABILITY (LTD) INSURANCE BENEFITS, AND APPROVAL OF A THREE-YEAR CONTRACT WITH METLIFE INSURANCE COMPANY FOR GROUP TERM LIFE INSURANCE – HUMAN RESOURCES (CONT.):

Funding: There will be no additional increase to the current budget and no additional cost to employees for the Group Long Term Disability benefits. The Group Term Life insurance benefits will result in a cost savings for the same level of benefit coverage.

SHERIFF'S OFFICE

13VV. AUTHORIZATION TO CREATE TWO (2) TEMPORARY, GRANT-FUNDED ACADEMY INSTRUCTOR POSITIONS, GRADE 36, PURSUANT TO A HUMAN TRAFFICKING GRANT AWARDED BY THE U. S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE AFFAIRS – SHERIFF'S OFFICE:

To **authorize** creation of two (2) temporary grant-funded Academy Instructor positions, Grade 36, pursuant to a Human Trafficking Grant awarded by the U. S. Department of Justice, Bureau of Justice Affairs, and **further authorize** the Chairman to execute the necessary documents.

Funding: Available in the FY05 Approved Grant Fund, as follows:

Transfer from: 270-210-G619-6326  
Transfer to: 270-210-G619-Appropriate Personal Services

COUNTY CLERK

13WW. APPROVAL OF MINUTES – COUNTY CLERK:

To **approve** minutes of the following meetings:

March 8, 2005 – Regular Meeting of the Board  
March 15, 2005 – Board of Commissioners Zoning Hearing

TRANSPORTATION

13XX. AUTHORIZATION TO ADVERTISE FOR A PUBLIC HEARING RELATIVE TO THE PROPOSED CLOSURE AND ABANDONMENT OF A PORTION OF DABNEY STREET AND THE REMAINDER OF AN UNIMPROVED ALLEYWAY LOCATED IN LAND LOT 696, 17<sup>TH</sup> DISTRICT, 2<sup>ND</sup> SECTION – TRANSPORTATION:

To **authorize** advertisement for a public hearing relative to the proposed closure and abandonment of a portion of Dabney Street and the remainder of an unimproved alleyway, ten (10) feet in width, located in Land Lot 696, 17<sup>th</sup> District, 2<sup>nd</sup> Section.



1000 Middle Street  
Middletown, CT 06457  
Grace Lewicki  
Sr. Client Svcs Support Consultant

May 2006

**Subject: Revision to your Group Policy**

To our valued customer:

The purpose of this letter is to notify you about changes to your Group Policy, which become effective on 06/01/2006.

We continually review the terms of our Group Policy and make changes as needed to ensure that we reflect both the preferences of our customers and current regulatory guidelines. The changes to your Group Policy are summarized below:

**GROUP POLICY CHANGES**

Generally we updated the policy to make it clearer and more understandable. The following provides additional information regarding the sections of the policy which have been updated:

**Section of the Policy – Part II – Policyholder and Insurance Company Matters**

**Clerical Error**

In the event of a clerical error Aetna will adjust premium if we determine that the error affects the existence of or the amount of insurance.

**Duties of the Policyholder**

The Data Required section has been replaced with a section called Duties of the Policyholder. This section provides greater clarity regarding your responsibility to maintain and retain the information required to administer the policy.

**Certificates**

Aetna may provide certificates in an electronic format.

**Policy Changes**

This section has been updated to provide you with a better understanding of the circumstances under which the policy may be amended with our without your consent.

**Fees**

A new section has been added to the Policy to make it clear that Aetna has the right to charge for any special service or function that we may agree to perform.

## Rider

Attached to and made a part of Group Policy No. GP-885645

a contract between

**Aetna Life Insurance Company**

and the Policyholder

**COBB COUNTY GOVERNMENT**

---

It is understood and agreed that the policy issued by Aetna Life Insurance Company in the State of Georgia, as constituted on the effective date of this rider, is hereby amended by adding or revising the following provisions within the policy.

---

### **Clerical Error**

A clerical error in keeping records; or a delay in making an entry; will not alone decide if insurance is valid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects:

the existence; or

amount;

of insurance, the facts as determined by Aetna will be used to decide if insurance is in force and its amount.

### **Duties of the Policyholder**

The Policyholder and each Member Employer must give Aetna such information as Aetna may reasonably require to administer this policy and must agree to:

Maintain a reasonably complete record of such information in electronic or hard copy format, including but not limited to:

evidence of eligibility;

changes to such elections; and

terminations;

for at least seven years or until the final rights and duties under this policy have been resolved; and to make such information available to Aetna upon request.

The information shall be provided when requested:

on Aetna forms; or

such other forms as Aetna may approve.

All data which may have a bearing on insurance or premiums will be open for Aetna to inspect while this policy is in force.

## Attachement 1

The Policyholder must notify employees of the termination of the policy in compliance with all applicable laws. However, Aetna reserves the right to notify employees of termination of the policy for any reason, including non-payment of premium. The Policyholder shall provide written notice to employees of their rights upon termination of coverage.

The Policyholder must:

notify all eligible employees of their right to continue coverage under any applicable state law; and

provide notification to each employee within 15 days after termination of coverage, of their conversion right, including:

a description of plans available;

premium rates;

and application forms.

### Certificates

Aetna will provide the Policyholder with either a supply of paper copies or electronic certificates. The Policyholder shall distribute or otherwise make the certificates available to each insured employee. The insurance in force will be set forth. Statements as to whom benefits are payable will appear. Any applicable Conversion Privilege will also be described.

### Policy Changes

This policy may be amended by Aetna:

with 30 days written notice to the Policyholder; or

by written agreement between Aetna and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Aetna. The Policyholder will not have to give written agreement of a change in the policy if:

- The Policyholder has asked for the change and Aetna has agreed to it.
- The change is needed to correct an error in the policy, including any certificate issued to anyone.
- The change is needed so that the policy will conform to any law, regulation or ruling of:
  - a jurisdiction that affects a person covered under this policy; or
  - the federal government.
- The change has been initiated by Aetna and is not resulting in either:
  - a reduction or elimination in benefits or coverage; or
  - an increase in premium

The Policyholder will have to give written agreement of a change in the policy:

that reduces or eliminates benefits or coverage; or

that increases benefits or coverage with a concurrent increase in premium during the policy term, except if the increased benefits or coverage is required by law.

## Attachement 1

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the Policyholder's written agreement of those changes on behalf of all persons covered under this policy.

This policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. This policy may also be amended by Aetna:

with 30 days written notice to the Policyholder; or

by written agreement between Aetna and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Aetna.

### **Premiums Due Experience Rating**

The premium due under this policy on any premium due date will be the sum of the premium charges for the coverages then provided under this policy.

If premiums are payable monthly, any insurance becoming effective will be charged for from the first day of the policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly, premium charges or credits for a fraction of a premium paying period will be made on a pro rata basis for the number of policy months between:

the date premium charges start or cease; and

the end of the premium paying period.

If this policy is changed to provide more coverage to take effect on a date other than the first day of a premium paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium paying period.

The premium charges will be figured at the premium rates shown before. Aetna may change them due to:

Experience; or

a change in factors bearing on the risk assumed.

Each change shall be made by written notice to the Policyholder by Aetna.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the group policy unless there is:

a significant change in factors bearing a material impact on the risk assumed by Aetna; or

changes in applicable state or federal:

law;

policy;

regulation; or

a judicial decision;

having a material impact on the cost of providing the coverages then provided under this group policy. As used here, "group policy" shall be deemed to include any group policy previously issued by Aetna that has been replaced in the whole or in part by this policy.

## Attachement 1

The Employee Life Insurance, Long Term and Managed Disability Benefits Coverage sections of this policy set forth the way in which the premium rates for such coverages will be figured. The premium charges for any other coverage under this policy may be refigured, as of a premium due date, only:

By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. 60 days advance notice has to be given to Aetna.

They will be refigured using:

The ages of the employees;

The amounts of insurance in force;  
The premium rates; and

Any other pertinent factors.

All facts will be taken as of the date of the refiguring.

At the end of a policy year, Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

If the sum of employee contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance, (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of employees. Aetna will not have to see to the use of such excess.

Instead of figuring premiums as described above, premiums may be figured in any way approved by Aetna that comes up with about the same amount of premiums.

Aetna will not have to refund any premium for a period prior to:

The first day of the policy year in which Aetna receives proof that the refund should be made; or

The date 3 months before Aetna receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

### **Premiums and Fees Due**

#### **Payment of Premiums and Fees**

The Policyholder will pay premiums and fees in advance. They may be paid at Aetna's Home Office or to its authorized agent.

A premium is due to be paid on the first day of each policy month.

The Policyholder may change the number of premium payments as of a premium due date. This needs Aetna's written consent.

Aetna may accept a partial payment of premium without waiving its right to collect the entire amount due.

## Attachement 1

If the premiums and any fees are not paid by the Premium Due Date and before the end of the Grace Period, this policy will automatically terminate when the Grace Period ends. Aetna will require the Policyholder to pay interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be 1 1/2% per month for each:

month; or

partial month;

the balance remains unpaid. Aetna may recover from the Policyholder:

costs of collecting any unpaid premiums or fees, including reasonable attorney's fees; and

costs of suit.

### **Grace Period**

A grace period of 31 days after the due-date will be allowed the Policyholder for the payment of each premium and fee. If premiums and fees are not paid by the end of the Grace Period, the policy will automatically terminate at the end of the Grace Period.

### **Discontinuance of Policy**

The Policyholder may terminate this policy as to any or all coverage of all or any class of employees of any one or more Member Employers. A Member Employer may terminate this policy as to any or all coverage of all or any class of its employees. Aetna must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Aetna as to the coverage.

Aetna may terminate this policy as to any or all coverage, other than Health Expense Coverage, which includes:

Comprehensive Medical Expense Coverage;

Major Medical Expense Coverage;

Prescription Drug Expense Coverage; and

Hospital Expense Benefit;

but does not include:

Comprehensive Dental Expense Coverage; and

Comprehensive Vision Expense Coverage;

of all or any class of employees or dependents of any one or more Member Employers by giving written notice of when it will terminate. The date shall not be earlier than 60 days after the date of the notice unless it is agreed to by the Policyholder and Aetna. This right to terminate shall be in accordance with the Grace Period and Payment of Premiums and Fees provisions and is subject to the terms of any laws or regulations.

Comprehensive Medical Expense Coverage; Major Medical; Prescription Drug Expense Coverage; Hospital Expense Benefit may be terminated by Aetna as follows:

When the premium for the employees' coverage has not been paid. This right to terminate shall be in accordance with the Grace Period and Payment of Premiums and Fees provisions and is subject to the terms of any laws or regulations.

When the Policyholder ceases to meet the requirements for a group as defined under applicable state law or regulation.

## Attachement 1

When the Policyholder fails to meet Aetna's contribution or participation requirements. Aetna may request:

certification of the Policyholder's compliance with Aetna's participation and contribution requirements; and  
certification of group status.

prior to renewal. Aetna may exercise its right to non-renew if such certification is not provided.

When the Policyholder fails, without good cause, to perform in good faith its obligations under this policy including an act or practice that constitutes fraud or intentional misrepresentation of a material fact relevant to the coverage provided under this policy while applying for or procuring insurance.

In accordance with any applicable state or federal law, rule or regulation.

When Aetna decides to discontinue offering:

a particular type of group health expense coverage; or

all its group health expense coverage in the state the policy is issued; provided all group health expense coverages issued or delivered for issuance in such state are discontinued and not renewed.

Except if Aetna discontinues offering a type of group health expense coverage, Aetna will give the Policyholder advance written notice of when it will terminate the policy. The date shall not be earlier than 60 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

If Aetna discontinues offering a particular type of group health expense coverage, it shall:

provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance within 90 days before such plans discontinue;

offer each affected employer the option, on a guaranteed issue basis; to purchase any other group health benefit plan currently being offered in that market; and

act uniformly without regard to the claims experience of the affected employers; or any health status-related factor relating to any covered employee or dependent who may become eligible for coverage.

If Aetna discontinues offering all its group health expense coverages, it shall provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance at least 180 days before such discontinuance.

If:

This policy terminates as to any of the employees of a Member Employer; and

Premiums and fees have not been paid for the period this policy; or any coverage included was in force for those employees;

then the Policyholder and the Employer shall be jointly and severally liable to Aetna for the unpaid premiums and fees, including those due for the grace period. Employees shall also remain liable for employee cost sharing and other required contributions to coverage for any period of time the policy is in force during the Grace Period.

Attachement 1

Aetna may request from the Policyholder, a written indication of their intention to renew or non-renew a policy at any time during the final three months of any policy year. If the Policyholder fails to reply to such request:

within two weeks of their receipt of the request; or

15 days prior to the renewal date;

whichever is later; then upon Aetna's written notice to the Policyholder, all or a part of the policy shall be deemed to terminate automatically as of the end of the policy year.

Similarly, upon Aetna's written confirmation to the Policyholder, Aetna may accept an oral indication by:

the Policyholder; or

its agent or broker;

of intent to non-renew as the Policyholder's notice of termination of all or a part of the policy effective as of the end of the policy year.

Aetna may charge the Policyholder a reinstatement fee if any or all coverage is terminated; and later reinstated under this policy.

**In Witness Whereof**, the Aetna Life Insurance Company has signed this rider at **Hartford, Connecticut**, to become effective on June 1, 2006.

Signed by the Insurance Company on May 1, 2006.



Ronald A. Williams  
President

Signed by the Policyholder on \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Official Title

## Attachment 2

**MetLife Group**  
2400 Lakeview Parkway, Suite 300, Alpharetta, GA 30004  
Tel (678)-319-2022 • Fax (678) -319-3437  
tremus@metlife.com

**Tom Remus**  
Account Executive

Registered Representative

August 16, 2007



Ms. Tracy Minjauw  
H R Manager  
Cobb County Board of Commissioners  
100 Cherokee Street  
Suite 350  
Marietta, GA 30090-9679

**Re: Cobb County Board of Commissioners #118427**  
**Revised Renewal - 5/1/2008**

Dear Tracy,

MetLife appreciates the opportunity to be a part of your benefit program. This letter confirms your renewal for the 2008 plan year.

I am pleased to advise you that the rates currently in effect will continue for the next 2 plan years commencing on 5/1/2008. In determining the rates for the plan year ahead we have evaluated your plan experience, taking into account the credibility of the experience and the demographics of your group. Our objective in the renewal process is to identify rates which will maintain the overall financial stability of your benefit program.

The rates for your contract with MetLife are as follows:

|                          | <u>Current Rates</u> | <u>Renewal Rates*</u> |
|--------------------------|----------------------|-----------------------|
| <b>Basic Life</b>        | \$0.142/ \$ 1000     | \$0.142/ \$ 1000      |
| <b>Basic AD&amp;D</b>    | 0.025/ \$ 1000       | 0.025/ \$ 1000        |
| <b>Optional Life</b>     |                      |                       |
| • Less than age 30       | 0.097/\$ 1000        | 0.097/\$ 1000         |
| • 30-34                  | 0.103/\$ 1000        | 0.103/\$ 1000         |
| • 35-39                  | 0.138/\$ 1000        | 0.138/\$ 1000         |
| • 40-44                  | 0.196/\$ 1000        | 0.196/\$ 1000         |
| • 45-49                  | 0.313/\$ 1000        | 0.313/\$ 1000         |
| • 50-54                  | 0.498/\$ 1000        | 0.498/\$ 1000         |
| • 55-59                  | 0.769/\$ 1000        | 0.769/\$ 1000         |
| • 60-64                  | 1.135/\$ 1000        | 1.135/\$ 1000         |
| • 65-69                  | 1.980/\$ 1000        | 1.980/\$ 1000         |
| • 70+                    | 2.320/\$ 1000        | 2.320/\$ 1000         |
| <b>Optional AD&amp;D</b> | 0.025/\$ 1000        | 0.025/\$ 1000         |
| <b>Dependent Life</b>    | 3.920 / EE           | 3.920 / EE            |

*\*Rates guaranteed 5/1/2008 – 4/30/2010*

## Attachment 2

The rates shown above assume your existing plan design, contribution structure and group demographics remain the same.

Please do not hesitate to contact me at 678-319-2022 if I may answer any questions or assist in any way.

Once again, thank you for the privilege you have extended to us. You are the reason we are in business and we look forward to continuing our mutually beneficial relationship in the months and years ahead.

Sincerely,



Tom Remus  
Account Executive

### **IMPORTANT INFORMATION:**

MetLife enters into arrangements with a variety of agents, brokers, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale of MetLife products (each an "Intermediary"). If you purchase a MetLife product through an Intermediary, MetLife may pay the Intermediary base commission and other forms of compensation for the sale and renewal of MetLife products and fees for the administration and service of MetLife products, or remit compensation to the Intermediary on your behalf, if you are a plan sponsor. As recognized by the National Association of Insurance Commissioners in its Producer Licensing Model Act, compensation may include payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, gifts, prizes, stock options or any other form of valuable consideration. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., consulting or reinsurance arrangements). If you would like further information, ask your Intermediary or a MetLife representative for specific details concerning your Intermediary's compensation arrangement with MetLife.

L05096LTC(exp1207)MLIC-LD.



Metropolitan Life Insurance Company  
One Madison Avenue, New York, New York 10010-3690

**APPLICATION FOR GROUP INSURANCE**

The applicant named below is applying for a Group Policy to provide insurance for the persons specified below.

**APPLICANT DATA**

- 1. Full legal name of Applicant: Cobb County Board of Commissioners (the "Policyholder")
- 2. Address: 100 Cherokee Street, Suite 350 City Marietta State GA Zip 30090-9679

**POLICY EFFECTIVE DATE**

The Group Policy's effective date will be May 1, 2005, subject to MetLife's acceptance of this application and the Applicant's payment of the Premium due on or before such date.

**POLICY SITUS**

The Group Policy will be issued for delivery in and governed by the laws of Georgia.

**COVERAGE DATA**

|   | Employees / Members Only            | Employees / Members and Dependents  |
|---|-------------------------------------|-------------------------------------|
| <u>Life Insurance</u>                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <u>Accidental Death and Dismemberment Insurance</u> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| <u> </u>  | <input type="checkbox"/>            | <input type="checkbox"/>            |

**PREMIUM DATA**

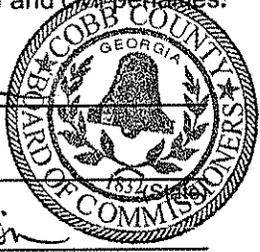
Premiums will be paid:  monthly  quarterly  annually  other: \_\_\_\_\_  
Attached is an advance payment of: \$ 63,093.34

**AGREEMENT**

The Applicant signing below agrees to accept the terms and provisions of the Group Policy, including its Exhibits, amendments and endorsements, if any.

**Fraud Warning.** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

*[Handwritten Signature]*



Samuel S. Olens  
Chairman, Cobb County  
Board of Commissioners

(Signature of Applicant's Legal Representative)

(Print Name and Title of Legal Representative)

Signed at: Marietta, GA  
(City)

Date: 4-28-05

*[Handwritten Signature: Candace W. Ellison]*  
(Signature of Witness)

Candace W. Ellison  
(Print Name of Witness)

\_\_\_\_\_  
(Signature of Licensed MetLife Agent or Resident Agent as required by law)

\_\_\_\_\_  
(Agent's State License No.)

\_\_\_\_\_  
(Print Name of Agent)

**APPROVED**  
PER MINUTES OF  
COBB COUNTY  
BOARD OF COMMISSIONERS  
3-22-05

**METLIFE**  
**NEW CUSTOMER NOTIFICATION FORM**

**TO:** RPC INST. NSC Tampa

**GROUP NAME:** Cobb County Board of Commissioners

**NSC REGION:** SOUTHERN

**EFFECTIVE DATE:** 5/1/05

**BINDER CHECK AMOUNT:** \$63,093.34

**MELLON BANK LOCKBOX ADDRESSES:**

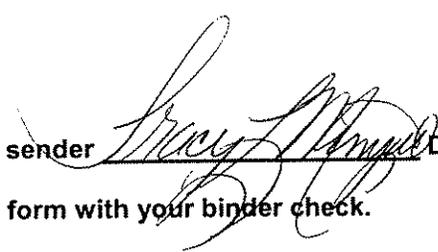
**METLIFE**

**DEPT CH10579 PALATINE IL 60055-0579**

**Customer Instructions**

1. **Enclose** your binder check with this form.
2. **Send** check to Mellon Bank lockbox address.
3. **Send** a copy of the check and application to:

Bridget Tapp  
**Metropolitan Life Insurance**  
2400 Lakeview Parkway  
Suite 300  
Alpharetta, GA 30004

Signature of sender  Date \_\_\_\_\_

Enclose this form with your binder check.



Metropolitan Life Insurance Company  
One Madison Avenue, New York, New York 10010-3690

Metropolitan Life Insurance Company ("MetLife"), a stock company, will pay the benefits specified in the Exhibits of this policy subject to the terms and provisions of this policy. The Schedule of Exhibits lists each Exhibit to this policy, to whom it applies and its effective date.

**Policyholder:** Cobb County Board of Commissioners

**Group Policy No.:** 118427-G

**EFFECTIVE DATE**

This policy will take effect on May 1, 2005.

**POLICY ANNIVERSARIES**

Policy anniversaries will be May 1, 2006 and each subsequent May 1.

**PREMIUM PAYMENTS**

This policy is issued in return for the payment by the Policyholder of required Premiums. Premiums are payable at the home office of MetLife or to its authorized agent. The first Premium is due on and must be paid by this policy's effective date. Any later Premiums are due monthly in advance on the first day of each Policy Month. These dates are the Premium Due Dates.

**POLICY SITUS**

This policy is issued for delivery in and governed by the laws of Georgia.

Signed as of this policy's effective date at MetLife's home office in New York, New York.

Gwenn L. Carr  
Senior Vice President and Secretary

C. Robert Henrikson  
President and Chief Operating Officer

Signed by Bridget A Japp  
(A MetLife licensed agent or resident agent as required by law.)

Date 4/6/05

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## Attachment 2

### DEFINITIONS

As used in this policy, the terms listed below will have the meanings defined below. When defined terms are used in this policy, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Contribution** means the amount the Policyholder may require the Employee to pay towards the total Premium that MetLife charges for the insurance provided by this policy.

**Contributory Insurance** means insurance for which the Policyholder may require the Employee to pay at least part of the Premium.

**Covered Person** means an Employee and/or a Dependent as set forth in the Exhibit which applies to the Employee.

**Dependent** is defined in the Exhibit which applies to the Employee.

**Employee** is described in the Exhibit which applies to the Employee.

**Employer** means the Policyholder shown on page 1.

**Noncontributory Insurance** means insurance for which the Policyholder may not require the Employee to pay any part of the Premium.

**Policy Anniversary** is defined on page 1.

**Policy Month.** The first Policy Month will begin on the effective date shown on page 1. Subsequent Policy Months will begin on the same day of each subsequent calendar month.

**Premium** means the amount the Policyholder must pay to MetLife for all the insurance provided under this policy.

**Premium Due Date** is defined on page 1.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

**Written or Writing** means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

## **SCHEDULE OF INSURANCE**

The Schedules of Insurance which apply under this policy are set forth in the Exhibits.

MetLife and the Policyholder have agreed that, a MetLife affiliate (the "Affiliate"), shall make will preparation service (the "Service") available to Employee's who elect group optional life insurance coverage. This Service will be made available at no cost to the Policyholder or to such Employee's during the period that group optional life insurance coverage is in effect.

## **ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE**

The Eligibility and Effective Dates of Insurance provisions that apply under this policy are set forth in the Exhibits.

## **CONTRIBUTIONS**

The Policyholder will not require an Employee to contribute to the cost of Noncontributory Insurance.

The maximum amount that an Employee may be required to contribute to the cost of Contributory Insurance will not exceed the Premium charged for the amounts of such insurance.

## **PREMIUM RATE(S)**

### **Initial Rate(s)**

The initial Premium rate(s) are shown in Exhibit 1.

### **Frequency of Premium Payment**

Premiums for this policy will be paid as shown on page 1. MetLife and the Policyholder may agree that payment be made in advance every 3, 6 or 12 months.

### **Computation of Premium**

The Premium due on any Premium Due Date is determined by the total amount of insurance provided by this policy on such Premium Due Date, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

MetLife may use any reasonable method to compute Premiums due under this policy.

### **Premiums for Changes in Insurance**

For insurance that takes effect after the first day of a Policy Month, Premium will be charged from the first day of the next Policy Month. However, if a policy amendment or evidence of good health is required for such insurance, Premium will be charged as of the date such insurance takes effect.

If this policy ends, or if insurance ends for a class of persons, Premium will be charged to the date insurance ends. If insurance ends for other reasons, Premium will be charged to the end of the Policy Month in which insurance ends.

**PREMIUM RATES (Continued)**

**Right to Change Premium Rates**

MetLife may change Premium rates for changes which materially affect the risk assumed for the insurance provided by this policy, as follows:

1. when this policy is amended or endorsed;
2. when a class of eligible persons is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;
3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;
4. when there is a significant change in the geographic distribution of insured Employees;
5. when applicable law requires a change in:
  - a. the insurance provided by this policy; and/or
  - b. the class of persons eligible for insurance under this policy; or
6. when a Premium Due Date coincides with or next follows:
  - a. a change greater than 10% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or
  - b. a change greater than 10% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.

In addition, MetLife may change Premium rates:

1. except as may be stated in Exhibit 1, on any date on or after the first Policy Anniversary; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 31 days before such change; and
2. on any other date agreed to by MetLife and the Policyholder.

The new Premium rates will apply only to Premiums due on or after the date the rate change takes effect.

**GRACE PERIOD**

Each Premium due after the effective date of this policy may be paid up to 31 days after its Premium Due Date. This period is the grace period. The insurance provided by this policy will stay in effect during this period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, this policy will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder, this policy will continue in effect until the date such notice is given.

**Policyholder's intent to end this policy during the grace period.** The Policyholder may notify MetLife in Writing prior to the end of the grace period of its intent to end this policy before the end of the grace period. In this case, this policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

If the Policyholder replaces this policy with another group insurance policy but does not give MetLife notice of intent to end this policy, the grace period provisions will apply.

**Grace period extensions.** MetLife may extend the grace period by giving Written notice to the Policyholder. Such notice will state the date this policy will end if the Premium remains unpaid.

Premiums must be paid for a grace period, any extension of such period and any period insurance under this policy was in effect for which Premium was not paid.

**END OF INSURANCE PROVIDED BY THIS POLICY**

The Policyholder can end this policy by giving 60 days advance Written notice to MetLife. The policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

MetLife can end this policy as follows:

1. on the date Premium is not paid when due, subject to the Grace Period provisions; or
2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if less than:
  - a. for Contributory Insurance other than Optional Life Insurance and Optional Accidental Death or Dismemberment Insurance, 75% of persons eligible under this policy are insured for such Contributory Insurance; or  
  
for Optional Life Insurance and Optional Accidental Death or Dismemberment Insurance 25% of persons eligible under this policy are insured for such Contributory Insurance; or
  - b. 100% of persons eligible under this policy are insured for Noncontributory Insurance; or
  - c. 50 Employees are insured by this Policy;
3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or

**END OF INSURANCE PROVIDED BY THIS POLICY (Continued)**

4. on any Policy Anniversary, except during a Rate Guarantee Period as may be provided in Exhibit 1, by giving the Policyholder 31 days advance Written notice.

This policy will end on the date on which the last certificate in effect under this policy ends.

If this policy ends, all Premiums due must be paid. If MetLife accepts Premium after the date this policy ends, such acceptance will not act to reinstate the policy. MetLife will refund any unearned Premium.

**REINSTATEMENT**

The Policyholder may request to reinstate this policy within one year from the date it ended. The request must be in Writing and it must provide MetLife with information that MetLife requires to consider such request. If MetLife approves the request, the policy will be reinstated on the date stated in Writing by MetLife.

**GENERAL PROVISIONS**

**Entire Contract.** The entire contract is made up of the following:

1. this policy, including its Exhibits;
2. the Policyholder's application; and
3. the amendments and endorsements to this policy, if any.

**Policy Changes or Waivers.** The terms and provisions of this policy may be changed, at any time, without the consent of the Covered Persons or anyone else with a beneficial interest in it. MetLife will issue amendments or endorsements to effect such changes. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement will not affect the insurance provided under certificates issued before the effective date of the change, unless retroactivity is consistent with applicable law.

An officer of MetLife must approve in Writing any change or waiver of the terms and provisions of this policy. A sales representative, or other MetLife employee, who is not an officer of MetLife does not have MetLife's authority to approve such changes or waivers. A change or waiver will be evidenced by an amendment Signed by an officer of MetLife and the Policyholder or an endorsement Signed by an officer of MetLife. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to this policy.

**Incontestability: Statements Made by the Policyholder.** Any statement made by the Policyholder will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application. MetLife will not use such statement to contest life insurance after it has been in force for 2 years from its effective date, or date of last reinstatement, unless the statement is fraudulent.

**Incontestability: Statements Made by Covered Persons.** Any statement made by a Covered Person will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. the Covered Person has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person or his beneficiary.

MetLife will not use a Covered Person's statements which relate to insurability to contest life insurance after it has been in force for 2 years during his life, unless the statement is fraudulent. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during his life, unless the statement is fraudulent.

**Certificates.** MetLife will issue certificates to the Policyholder for delivery to each Covered Person, as appropriate. Such certificate will describe the Covered Person's benefits and rights under this policy. "Certificate" includes any of MetLife's insurance riders, notices or other attachments to the certificate.

**GENERAL PROVISIONS (Continued)**

**Assignment.** The life insurance rights and benefits under this policy are assignable by gift. The Life Insurance benefits for an Employee under this Policy are also assignable by means of a viatical assignment. In this case, MetLife will recognize the assignee(s) under such assignment as owner(s) of the Employee's right, title and interest under this policy if:

1. a Written form satisfactory to MetLife, affirming this assignment, has been completed;
2. the Written form has been Signed by the Employee, assignee(s) and Policyholder; and
3. the Written form is delivered to MetLife for recording.

MetLife is not responsible for the validity of an assignment. All other insurance under this policy may not be assigned prior to a claim for benefits, except as required by law or as permitted by MetLife.

**Data Needed.** The Policyholder will provide MetLife with all the data needed to compute Premiums and carry out the terms of this policy. MetLife may examine such data at any reasonable time. If MetLife or the Policyholder make a clerical error in keeping the data, the Premium and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in effect, nor will it continue insurance validly ended.

**Misstatement of Age.** If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust the Premium and/or benefits.

**Non-Dividend Paying.** This policy does not pay dividends.

**Conformity with Law.** If the terms and provisions of this policy do not conform to any applicable law, this policy shall be interpreted to so conform.

Attachment 2

**SCHEDULE OF EXHIBITS**

| <b>Exhibit<br/>Number</b> | <b>Exhibit Type</b>       | <b>Applies To</b>      | <b>Effective<br/>Date</b> |
|---------------------------|---------------------------|------------------------|---------------------------|
| 1                         | Schedule of Premium Rates | All Covered<br>Persons | May 1, 2005               |
| 2                         | Certificate Forms         | All Covered<br>Persons | May 1, 2005               |

## Attachment 2

### EXHIBIT 1

#### SCHEDULE OF PREMIUM RATES

The initial monthly Premium rates for the insurance provided by this policy are as follows:

##### Rate Guarantee Period

Subject to the Right to Change Premium Rates provision on page 5, the Basic Life, Accidental Death and Dismemberment, Optional Life, Dependent Life Premium rates will be in effect for the period which begins on May 1, 2005 and ends on April 30, 2008.

Basic Life Benefits for Employees: - \$.142 per \$1,000 of Basic Life Benefits in force hereunder.

Optional Life Benefits for Employees:

| <u>Age of Employee</u> | <u>Amount Per \$1,000 of<br/>Optional Life Benefits<br/>in force hereunder</u> |
|------------------------|--|
| Less than 30           | \$0.097  |
| 30 but less than 35    | 0.103  |
| 35 but less than 40    | 0.138  |
| 40 but less than 45    | 0.196  |
| 45 but less than 50    | 0.313  |
| 50 but less than 55    | 0.498  |
| 55 but less than 60    | 0.769  |
| 60 but less than 65    | 1.135  |
| 65 but less than 70    | 1.980  |
| 70 +                   | 2.320  |

Personal Accidental Death or Dismemberment Benefits for Employees: - \$.025 per \$1,000 of the Full Amount of Accidental Death or Dismemberment Benefits for Employees.

Optional Accidental Death or Dismemberment Benefits for Employees: - \$.025 per \$1,000 of the Full Amount of Accidental Death or Dismemberment Benefits for Employees.

Life Benefits for Dependents: - \$3.92 per Employee.

**EXHIBIT 2**

**CERTIFICATE FORMS**

| <b>Certificate Number</b> | <b>Certificate Form</b> | <b>Applies To</b>              | <b>Effective Date</b> |
|---------------------------|-------------------------|--------------------------------|-----------------------|
| 1                         | GCERT2000               | All Full-Time Active Employees | May 1, 2005           |

The following disabled persons will be insured for Life Insurance insurance amounts that were in effect for them on May 1, 2005, as follows:

| <b>Employee Name</b> | <b>Birthday</b> | <b>Sex</b> | <b>Original Effective Date</b> | <b>Amount</b> |
|----------------------|-----------------|------------|--------------------------------|---------------|
|----------------------|-----------------|------------|--------------------------------|---------------|

## Attachment 3

**Cobb County Government**

**Long Term Disability**

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# Your Group Coverage Plan

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This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.



President

Cert. Base: 1  
Issue Date: May 11, 2005  
Effective Date: May 1, 2005

# Long Term Disability Coverage

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This Plan will pay a Monthly Benefit for a period of disability caused by a disease or **injury**. There is an elimination period. (This is the length of time during a period of disability that must pass before benefits start.)

---

## Test of Disability

From the date that you first become disabled and until Monthly Benefits are payable for 24 months, you will be deemed to be disabled on any day if:

- you are not able to perform the **material duties** of your **own occupation** solely because of: disease or **injury**; and
- your work earnings are 80% or less of your **adjusted predisability earnings**.

After the first 24 months that any Monthly Benefit is payable during a period of disability, you will be deemed to be disabled on any day if you are not able to work at any **reasonable occupation** solely because of:

- disease; or
- **injury**.

If your **own occupation** requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of the loss of that license or certification.

---

## Monthly Benefit

The Scheduled Monthly LTD Benefit, the Maximum Monthly Benefit, and the Minimum Monthly Benefit are shown on the Summary of Coverage.

The monthly benefit is an amount based on your monthly predisability earnings. Other income benefits, as defined later, are taken into account.

- If no other income benefits are payable for a given month:

The monthly benefit payable under this Plan for that month will be the lesser of:

- the Scheduled Monthly LTD Benefit; and
- the Maximum Monthly Benefit.

- If other income benefits are payable for a given month:

The monthly benefit payable under this Plan for that month will be the lesser of:

- the Scheduled Monthly LTD Benefit; and
- the Maximum Monthly Benefit;

minus all other income benefits, but not less than the Minimum Monthly Benefit.

## When Benefits Are Payable

Monthly benefits will be payable if a period of disability:

- starts while you are covered; and
- continues during and past the elimination period.

These benefits are payable after the elimination period ends for as long as the period of disability continues.

---

## A Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a **physician**. (You will not be deemed to be under the regular care of a **physician** more than 31 days before the date he or she has seen and treated you in person for the disease or **injury** that caused the disability.)

Your period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date Aetna finds that you have withheld information which indicates you are performing, or are capable of performing, the duties of a **reasonable occupation**.
- The date you refuse to be examined by, or cooperate with, an independent **physician** or a licensed or certified health care practitioner, as requested.
- The date you cease to be under the regular care of a **physician**.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Benefit Duration.
- The date you are not undergoing **effective treatment for alcoholism or drug abuse**, if your disability is caused to any extent by alcoholism or drug abuse.
- The date you refuse to cooperate with or accept:

changes made to a work site or job process to suit your identified medical limitations; or

adaptive equipment or devices designed to suit your identified medical limitations;

which would enable you to perform your **own occupation** or a **reasonable occupation** (if you are receiving benefits for being unable to work any **reasonable occupation**) and provided that a **physician** agrees that such changes or adaptive equipment suit your medical limitations.

- The date you refuse to receive treatment recommended by your attending **physician** that in Aetna's opinion would: cure; correct; or limit your disability.
- The date your condition would permit you to work, or increase the number of hours you work, or the number or type of duties you perform in your **own occupation**, but you refuse to do so.
- The date of your death.
- The day after Aetna determines you are able to participate in an **Approved Rehabilitation Program** and you refuse to do so.

A period of disability will end after 24 monthly benefits are payable if it is determined that the disability is primarily caused by:

- a Mental Health or Psychiatric condition, including physical manifestations of these conditions, but excluding those conditions with demonstrable, structural brain damage; or
- Alcohol and/or Drug Abuse.

There are two exceptions which apply if you are confined as an inpatient in a **hospital** or **treatment facility** for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the period of disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of disability may continue until 90 days after the date you have not been so continuously confined.

The Separate Periods of Disability section does not apply beyond 24 months to periods of disability which are subject to the above paragraph.

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### **How Separate Periods of Disability Are Treated**

Once a period of disability has ended, any new period of disability will be treated separately.

However, 2 or more separate periods of disability due to the same or related causes will be deemed to be one period of disability and only one elimination period will apply if:

the separation occurs during the elimination period and the periods are separated by less than 15 days in a row of work.

the separation occurs after the elimination period and the periods are separated by less than 6 months in a row of work.

The first period will not be included if it began while you were not covered under this LTD Plan.

If you become eligible for coverage under any other group long term disability benefits plan carried or sponsored by your Employer, this Separate Periods of Disability section will cease to apply to you.

---

### **Other Income Benefits**

They are:

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:

Unemployment compensation benefits.

Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.

Automobile no-fault wage replacement benefits to the extent required by law.

Statutory disability benefits.

Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.

Veterans' benefits.

- Disability or unemployment benefits under any plan or arrangement of coverage:

as a result of employment by or association with the Employer; or

as a result of membership in or association with any group, association, union or other organization.

This includes both, plans that are insured and those that are not.

- Unreduced retirement benefits for which you are or may become eligible under a group pension plan at the later of:

age 62, and

the Plan's Normal Retirement Age,

but only to the extent that such benefits were paid for by an employer.

- Voluntarily elected retirement benefits received under any group pension plan; but only to the extent that such benefits were paid for by an employer.
- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.
- Disability benefits under any group mortgage or group credit disability plan.

Other income benefits include those, due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents.

---

### **Effect of Increases In Other Income Benefits On Monthly Benefits**

Increases in the level of other income benefits due to the following will be considered "other income benefits":

- a change in the number of your family members;
- a recomputation or recalculation to correct or adjust your benefit level as first established for the period of disability; or
- a change in the severity of your disability.

There may be cost of living increases in the level of other income benefits received from a governmental source during a period of disability. These increases will not be deemed to be "other income benefits."

There may be cost of living or general increases in the level of other income benefits from a non-governmental source during a period of disability. These increases will not be considered other income benefits to the extent they are based on the annual average increase in the **Consumer Price Index**.

---

### **Other Income Benefits Which Do Not Reduce Monthly Benefits**

The amount of any retirement or disability benefits you were receiving from the following sources before the date you become disabled under this LTD Plan will not reduce your monthly benefits:

- military and other government service pensions;
- retirement benefits from a prior employer;
- veterans' benefits for service related disabilities;
- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your monthly benefits:

- profit sharing plans;
- thrift plans;
- 401(k) plans;
- Keogh plans;
- employee stock option plans;
- tax sheltered annuity plans;
- severance pay;
- individual disability income policies; or
- individual retirement accounts (IRAs).

Aetna will determine other income benefits as follows:

### **Lump Sum and Periodic Payments From Any Other Income Benefits**

Any lump sum or periodic other income payments that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over a reasonable period of time, taking into account the expected length of disability benefits and other relevant factors.

That part of the lump sum or periodic payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. If there is no proof acceptable to Aetna as to what that part reasonably is, 50% will be deemed to be for disability.

Any of these "Other Income Payments" that date back to a prior date may be allocated on a retroactive basis.

### **Estimated Payments**

The amount of other income benefits for which you appear to be eligible will be estimated, unless you have signed and returned a reimbursement agreement to Aetna. This agreement contains your promise to repay Aetna for any overpayment of benefits made to you.

If other income benefits are estimated, your monthly benefit will be adjusted when we receive proof:

- of the exact amount awarded; or
- that benefits have been denied after review at the highest administrative level.

Aetna will pay you if any underpayment in your monthly benefit results. You will have to repay Aetna if any overpayment results. When Aetna has to take legal action against you to recover any overpayment, you will also have to pay Aetna's reasonable attorney's fees and court costs, if Aetna prevails.

---

### **Required Proof of Income**

Aetna has the right to require proof that:

- you have made application for all other income benefits which you are, or may be, eligible to receive relative to your disability and have made a timely appeal of any denial through the highest Administrative level;
- the person has furnished proof needed to obtain other income benefits;
- the person has not waived any other income benefits without Aetna's written consent; and
- the person has sent copies of the documents to Aetna showing the effective dates and the amounts of other income benefits.

Aetna also requires proof:

- of income you receive from any occupation for compensation or profit; and
- if your income from any such occupation is 80% or less of your **adjusted predisability earnings**, proof that you are unable, due to disease or **injury**, to earn more than 80% of your **adjusted predisability earnings**.

If you do not furnish proof of other income benefits, Aetna reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.

### **Approved Rehabilitation Program**

Aetna retains the right to evaluate you for participation in an **Approved Rehabilitation Program**.

If, in Aetna's judgment, you are able to participate, Aetna may, in its sole discretion require you to participate in an **Approved Rehabilitation Program**.

This Plan will pay for all services and supplies, approved in advance by Aetna, needed in connection with such participation; except for those for which you can otherwise receive reimbursement from any third party payor, including any governmental benefits to which you may be entitled.

## Exclusions

Long Term Disability Coverage does not cover any disability that:

- is due to intentionally self-inflicted **injury** (while sane or insane).
- results from your commission of, or attempting to commit, a criminal act.
- results from driving an automobile while intoxicated. ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law.)
- is due to war or any act of war (declared or not declared).
- is due to: insurrection; rebellion; or taking part in a riot or civil commotion.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

---

## Pre-existing Conditions

No benefit is payable for any disability that is caused by or contributed to by a "pre-existing condition" and starts before the end of the first 12 months following your effective date of coverage.

A disease or **injury** is a pre-existing condition if, during the 3 months before your effective date of coverage:

- it was diagnosed or treated; or
- services were received for the diagnosis or treatment of the disease or **injury**; or
- you took drugs or medicines prescribed or recommended by a **physician** for that condition.

# General Information About Your Coverage

(including information about Termination of Coverage and the Effect of Prior Coverage)

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## Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Ceasing active work will be deemed to be cessation of employment. If you are not at work due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or **injury**, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment will be deemed to cease on your last full day of active work before the start of the lay-off or leave of absence.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

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## Benefits May Continue After Termination

If your coverage ceases during a period of disability which began while you had coverage, benefits will be available as long as your period of disability continues.

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## Reinstatement of Coverage

If your coverage terminates, you may again become covered in accordance with the terms of this Plan; except that:

- If:

you return to active work within 6 months of the date coverage terminated; and

you request coverage from your Employer within 31 days of your return to active work;

any Limitation as to a pre-existing condition will apply only to the extent it would have applied if your coverage had not terminated. Also, any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

- If:

you return to active work between the 7th and the 24th month following the date coverage terminated; and

you request coverage from your Employer within 31 days of your return to active work;

any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

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### **How "Prior Coverage" Affects Coverage Under This Plan**

If the coverage of any person under this Plan replaces any prior coverage of the person, the following will apply.

"Prior coverage" is any plan of group long term disability coverage that has been replaced by coverage under part or all of this Plan. It must have been sponsored by your Employer who is participating in this Plan. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

A person's coverage under this Plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage except coverage will not be available as to a particular period of disability for which a benefit is available or would be available under the prior coverage in the absence of coverage under this Plan.

As stated earlier, this Plan has a Limitation as to a disability caused by a pre-existing condition.

However, if:

- you had prior coverage on the day before Long Term Disability Coverage took effect; and
- you became covered for this LTD Plan on the date it takes effect;

such Limitation applies only until a continuous period of coverage under the prior coverage and this LTD Plan are equal to the lesser of:

- 12 months; and
- any period of limitation as to a pre-existing condition remaining under the prior coverage.

Where the Limitation no longer applies, the amount of monthly benefit and the maximum period for which benefits will be payable, as to a period of disability caused by such pre-existing condition, will be as provided in this LTD Plan.

In no event will:

- A benefit be payable as to a period of disability caused by a pre-existing condition, if the disability is excluded by any other terms of this LTD Plan.
  - A condition be considered to be a pre-existing condition under this LTD Plan if it was not a pre-existing condition under the prior coverage.
- 

### **Survivor Benefit**

If you die while disabled, a single, lump sum benefit will be paid under this provision if:

- there is an Eligible Survivor as defined below; and
- a Monthly Benefit was payable under this Plan.

The benefit amount will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full Monthly Benefit, however, the benefit will be:

- 3 times the Monthly Benefit, not reduced by other income benefits for which you would have been eligible if you had not died, for the first full month after the month in which you die.

An Eligible Survivor is:

- Your legally married spouse at the date of your death.
- If there is no such spouse, your biological or legally adopted child who, when you die:

is not married; and

is depending mainly on you for support; and

is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

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### **How the Survivor Benefit Will Be Paid**

The benefit will be paid as soon as the necessary written proof of your death and disability status is received.

The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

If Monthly Benefit payments are made in amounts greater than the Monthly Benefits that you are entitled to receive, Aetna has the right to first apply the survivor benefit to any such overpayment.

Aetna may pay the benefit to anyone who, in Aetna's opinion, is caring for and supporting the eligible survivor; or, if proper claim is made, Aetna may pay the benefit to an eligible survivor's legally appointed guardian or committee.

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### **Assignment of Insurance**

Coverage may be assigned only with the consent of Aetna.

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### **How and When To Report Your Claim**

You are required to submit a claim to Aetna by following the procedure chosen by your Employer. If the procedure requires that claim forms be submitted, they may be obtained at your place of employment or from Aetna. Your claim must give proof of the nature and extent of the loss. Aetna may require copies of documents to support your claim, including data about any other income benefits. You must also provide Aetna with authorizations to allow it to investigate your claim and your eligibility for and the amount of other income benefits.

You must furnish such true and correct information as Aetna may reasonably request.

The deadline for filing a claim for benefits is 90 days after the end of the elimination period. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will be accepted if you file as soon as possible; but not later than 1 year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

### **How Benefits Will Be Paid**

Benefits will be paid to you at the end of each calendar month during the period for which benefits are payable. Benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Any unpaid balance at the end of Aetna's liability will be paid within 15 days of receipt by Aetna of the due written proof. If the claim has not been paid, or has not been denied for valid and proper reasons, by the end of the 15 day period, Aetna will pay the insured or claimant interest on accrued benefits at the rate of 18 percent per annum on the amount of the claim, until the claim is settled.

Aetna may pay up to \$ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

### **Examinations and Evaluations**

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable. This will be done at Aetna's expense.

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### **Legal Action**

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

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### **Child Care Benefit**

If:

- you are participant in an **Approved Rehabilitation Program**; and
- you have a dependent child;

The benefit payable under this Plan may be increased as described below.

Starting after the first 6 months of a period of disability for which a Monthly Benefit is payable, the benefit payable will be increased by an amount equal to the amount charged by a licensed day care provider for the care of such child while you are such a participant. In no event will the increase in any one month be more than:

- \$250 for each child; or
- \$500 for all children

Not more than 24 such monthly increases will occur during any one period of disability.

During any month in which a child care benefit is payable to a person, the Maximum Monthly Benefit for that person will be increased by the amount of the child care benefit payable for that month.

"Dependent child" means a child care who is under age 13 and who lives with you and is either:

- Your or your spouse's biological child.
- Your or your spouse's legally adopted child.
- A child for whom you are legal guardian.

A 'licensed day care provider' will not include: one who is a member of your immediate family; or one who lives in your residence.

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### **Contract Not a Substitute for Workers' Compensation Insurance**

The group contract is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

### **General Provisions**

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.

## Attachment 3

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- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer who may direct you to a local Aetna office. Otherwise, you may write to the following address:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, Connecticut 065156  
Attention: Benefit Contracts Legal MB58

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

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# Glossary

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The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

## Adjusted Predisability Earnings

This is your **predisability earnings** plus any increase made on each January 1, starting on the January 1 following 12 months of a period of disability. The increase on each such January 1 will be by the percentage increase in the **Consumer Price Index**, rounded to the nearest tenth; but not by more than 10%.

## Approved Rehabilitation Program

This is a written program approved by Aetna which provides for services and supplies that are intended to enable you to return to work. This program may include, but is not limited to:

- vocational testing;
- vocational training;
- alternative treatment plans such as:
  - support groups;
  - physical therapy;
  - occupational therapy;
  - speech therapy;
- workplace modification to the extent not otherwise provided;
- part time employment; and
- job placement.

A rehabilitation program will cease to be **An Approved Rehabilitation Program** on the date Aetna withdraws, in writing, its approval of the program.

## Consumer Price Index

The CPI-W, Consumer Price Index for Urban Wage Earners and Clerical Workers is published by the United States Department of Labor. If the CPI-W is discontinued or changed, Aetna reserves the right to use a comparable index.

## Effective Treatment of Alcoholism or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means solely treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means primarily providing an environment free of alcohol or drugs.

## Hospital

This is an institution that:

- mainly provides, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons; and
- is supervised by a staff of **physicians**; and

- provides 24 hour a day registered nursing (RN) service; and
- is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

An institution which does not provide complete surgical services, but which meets all the other tests listed above, will also be deemed a hospital if:

- it provides services chiefly to patients all of whom have conditions related either by a medical specialty field or a specific disease category; and
- while confined, the patient is under regular therapeutic treatment by a **physician** for the **injury** or disease.

### **Injury**

An accidental bodily injury.

### **Material Duties**

These are duties that:

- are normally required for the performance of your **own occupation**; and
- cannot be reasonably: omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

### **Own Occupation**

This is the occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- for your specific employer; or
- at your location or work site; and

without regard to your specific reporting relationship.

### **Physician**

"Physician" means a person who is a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Regular care of a physician means you are attended by a physician:

- who is not you or related to you;
- who is practicing within the scope of his or her license;
- who has the medical training and clinical expertise suitable to treat your disabling condition;
- who specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- whose treatment is:

consistent with the diagnosis of the disabling condition; and  
according to guidelines established by medical, research and rehabilitative organizations; and  
administered as often as needed.

### **Predisability Earnings**

This is the amount of salary or wages you were receiving from an employer participating in this Plan on the day before a period of disability started, calculated on a monthly basis.

It will be figured from the rule below that applies to you.

If you are paid on an annual contract basis, your monthly salary is 1/12th of your annual contract salary.

If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.

If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 173 hours per month.

Included in salary or wages are:

- Commissions averaged over the last 12 months of actual employment or such shorter period if actual employment was for fewer than 12 months.
- Contributions you make through a salary reduction agreement with your Employer to any of the following:

An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.

An IRC 401(k), 403(b), or 457 deferred compensation arrangement.

An executive nonqualified deferred compensation agreement.

Not included in salary or wages are:

- Awards and bonuses.
- Overtime pay.
- Contributions made by your Employer to any deferred compensation arrangement or pension plan.

A retroactive change in your rate of earnings will not result in a retroactive change in coverage.

### **Reasonable Occupation**

This is any gainful activity for which you are; or may reasonably become; fitted by: education; training; or experience; and which results in; or can be expected to result in; an income of more than 80% of your **adjusted predisability earnings**.

### **Treatment Facility**

This is an institution (or distinct part thereof) that is for the treatment of alcoholism or drug abuse and which meets fully every one of the following tests:

- It is primarily engaged in providing on a full-time inpatient basis, a program for diagnosis, evaluation, and treatment of alcoholism or drug abuse.
- It provides all medical detoxification services on the premises, 24 hours a day.
- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse, on a 24 hour daily basis. Also, it provides, or has an agreement with a **hospital** in the area to provide, any other medical services that may be required during the treatment period.
- On a continuous 24 hour daily basis, it is under the supervision of a staff of **physicians**, and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a **physician**.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

## **Confidentiality Notice**

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at [www.aetna.com](http://www.aetna.com).

**Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law**

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.



**YOUR BENEFIT PLAN**

**Cobb County Board of Commissioners**

**Basic Life Insurance**

**Optional Life Insurance**

**Dependent Life Insurance**

**Accidental Death and Dismemberment Insurance**

**Optional Accidental Death and Dismemberment Insurance**

## Attachment 4

Cobb County Board of Commissioners  
100 Cherokee Street, Suite 350  
Marietta, GA 30090-9679

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Cobb County Board of Commissioners



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

**CERTIFICATE OF INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

**Policyholder:** Cobb County Board of Commissioners

**Group Policy Number:** 118427-1-G

**Type of Insurance:** Term Life & Accidental Death and Dismemberment Insurance

**MetLife Toll Free Number(s):**  
**For Claim Information** FOR LIFE CLAIMS: 1-800-638-6420

**THIS CERTIFICATE ONLY DESCRIBES LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.**

**THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.**

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.**

**For Residents of North Dakota:** If you are not satisfied with your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if you elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under your Certificate will not be covered.

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

**For Texas Residents:**

**Para Residentes de Texas:**

**IMPORTANT NOTICE**

**AVISO IMPORTANTE**

To obtain information or make a complaint:

Para obtener informacion o para someter una queja:

You may call MetLife's toll free telephone number for information or to make a complaint at

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-6420

1-800-638-6420

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

1-800-252-3439

You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

**PREMIUM OR CLAIM DISPUTES:** Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:**  
This notice is for information only and does not become a part or condition of the attached document.

**UNA ESTE AVISO A SU CERTIFICADO:**  
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

**NOTICE FOR RESIDENTS OF ALL STATES**

**LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID**

**DISCLOSURE:** The Life Insurance accelerated benefit offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from Your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive an accelerated benefit excludable from income under federal law.

**DISCLOSURE:** Receipt of an accelerated benefit 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 payment will affect Your, Your Spouse's and Your family's eligibility for public assistance.

**NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third  
Little Rock, Arkansas 722014-1904  
1-800-852-5494

**NOTICE FOR RESIDENTS OF CALIFORNIA**

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.**

**IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1 (800) 927-4357**

**NOTICE FOR RESIDENTS OF GEORGIA**

**IMPORTANT NOTICE**

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

**NOTICE FOR RESIDENTS OF ILLINOIS**

**IMPORTANT NOTICE**

To make a complaint to MetLife You may write to:

MetLife  
1 Madison Avenue  
New York, New York 10010

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR MASSACHUSETTS RESIDENTS**

### **CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE**

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your AD&D Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

**Plant Closing** and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

**NOTICE FOR RESIDENTS OF MINNESOTA**

This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long-term care policy meeting the requirements of sections M.S.62A.46 to 62A.56 or chapter 62S.

**NOTICE FOR RESIDENTS OF NORTH CAROLINA**

**Read your Certificate Carefully.**

**IMPORTANT CANCELLATION INFORMATION**

**Please Read The Provisions Entitled**

**DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR  
YOUR DEPENDENTS ENDS**

**Found on Pages e/ee and e/dep**

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, FOR WHICH PAYMENT WAGES OR OTHER FUNDS ARE WITHHELD FROM THE PERSONS INSURED, SHALL:

1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO EACH NAMED INSURED A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO THE NAMED INSURED OF THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

**Violation of this law is a felony if the insurance is, in whole or in part, paid for out of wages withheld or other funds collected from the persons insured. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.**

**NOTICE FOR RESIDENTS OF NORTH DAKOTA**

**FREE LOOK PERIOD FOR LIFE AND HEALTH INSURANCE**

If You are not satisfied with Your certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 30 days of Our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums losses which otherwise would have been covered under Your certificate will not be covered.

## **NOTICE FOR RESIDENTS OF UTAH**

### **NOTICE TO POLICYHOLDERS**

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

### **PEOPLE ENTITLED TO COVERAGE**

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

### **POLICIES COVERED**

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

### **EXCLUSIONS AND LIMITATIONS**

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

### **LIMITS ON AMOUNT OF COVERAGE**

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.

## Attachment 4

- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

### DISCLAIMER

**PLEASE READ CAREFULLY:**

**COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

**COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

**THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

**INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

**THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance  
Guaranty Association  
955 E. Pioneer Rd.  
Draper, Utah 84114

Utah Insurance Department  
State Office Building, Room 3110  
Salt Lake City, Utah 84114

## CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to Your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.
- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.
- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.
- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions".

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under Your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of "dependent" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in Your certificate. It broadens definitions and terms only to the extent required by Vermont law.

### **DISCLOSURE:**

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

**FOR RESIDENTS OF VIRGINIA**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife  
1 Madison Avenue  
New York, New York 10010  
Attn: Corporate Customer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:  
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23209  
1-800-552-7945 - In-state toll-free  
1-804-371-9691 - Out-of-state

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

## Attachment 4

### **NOTICE FOR RESIDENTS OF WEST VIRGINIA**

#### **FREE LOOK PERIOD:**

If You are not satisfied with Your certificate, You may return it to Us within 10 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 10 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

**NOTICE FOR RESIDENTS OF WISCONSIN**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

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

MetLife  
Attn: Corporate Consumer Relations Department  
1 Madison Avenue  
New York, NY 10010-3690  
1-800-638-5433

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

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517 outside of Madison or 266-0103 in Madison.

## **NOTICE FOR RESIDENTS OF ALL STATES FRAUD WARNING**

If You have applied for insurance under a policy issued in one of the following states, or if You reside in one of the following states, note the following applicable warning:

### **For Residents of New York - only applies to Accident and Health Insurance (AD&D/Disability/Dental)**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### **For Residents of Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

### **For Residents of Kansas and Massachusetts**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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, and may subject such person to criminal and civil penalties.

### **For Residents of New Jersey**

Any person who includes any false or misleading information on an application for an insurance policy or who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

### **For Residents of Oklahoma**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

### **For Residents of Oregon**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

### **For Residents of Virginia**

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or statement of claim containing a false or deceptive statement may have violated state law.

### **For Residents of All Other States**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

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**SCHEDULE OF BENEFITS**

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

**BENEFIT**

**BENEFIT AMOUNTS AND HIGHLIGHTS**

**Life Insurance For You**

**Basic Life Insurance**

For All Other Eligible Employees:

|   |   |
|---|---|
| For Active Employees .....  | An amount equal to 2 times Your Basic Annual Earnings, rounded to the next higher \$1,000 |
|   |   |
| Maximum Benefit for Basic Life and Optional Life Insurance Combined Benefit .....   | \$2,500,000   |
| Non-Medical Issue Amount for Life and Optional Life Insurance Combined Benefit..... | \$1,000,000   |
| Accelerated Benefit Option .....  | Up to 50% of Your Basic Life amount not to exceed \$250,000                               |

For Judges:

|   |   |
|---|---|
| For Active Employees .....  | An amount equal to 1 times Your Basic Annual Earnings, rounded to the next higher \$1,000 |
|   |   |
| Maximum Benefit for Basic Life and Optional Life Insurance Combined Benefit .....   | \$2,500,000   |
| Non-Medical Issue Amount for Life and Optional Life Insurance Combined Benefit..... | \$1,000,000   |
| Accelerated Benefit Option .....  | Up to 50% of Your Basic Life amount not to exceed \$250,000                               |

**SCHEDULE OF BENEFITS (continued)**

For Senior Superior Judges:

|   |  |
|---|--|
| For Active Employees .....  | An amount equal to 1 times Your Basic Annual Earnings , rounded to the next higher \$1,000 or \$50,000 whichever is greater. |
| Maximum Benefit for Basic Life and Optional Life Insurance Combined Benefit .....   | \$2,500,000  |
| Non-Medical Issue Amount for Life and Optional Life Insurance Combined Benefit..... | \$1,000,000  |
| Accelerated Benefit Option .....  | Up to 50% of Your Basic Life amount not to exceed \$250,000  |

**Optional Life Insurance**

For Active Employees:

|   |   |
|---|---|
| For All Active Employees .....  | An amount equal to 1 times Your Basic Annual Earnings, rounded to the next higher \$1,000 |
| Maximum Benefit for Basic Life and Optional Life Insurance Combined .....           | \$2,500,000   |
| Non-Medical Issue Amount for Life and Optional Life Insurance Combined Benefit..... | \$1,000,000   |
| Accelerated Benefit Option .....  | Up to 50% of Your Optional Life amount not to exceed \$250,000                            |

**SCHEDULE OF BENEFITS (continued)**

**Accidental Death and Dismemberment Insurance (AD&D) for You**

**Full Amount for Basic AD&D**

For Active Employees:

For Active Employees..... An amount equal to Your Basic Life Insurance.

Maximum Accidental Death and Dismemberment Full Amount ..... \$2,500,000

**Additional Benefits:**

Seat Belt Benefit..... Yes

Air Bag Use Benefit..... Yes

Common Carrier Benefit..... Yes

**Schedule of Covered Losses for Accidental Death and Dismemberment Insurance**

All amounts listed are stated as percentages of the Full Amount.

**Covered Losses**

Loss of life ..... 100%  
 Loss of a hand permanently severed at or above the wrist but below the elbow..... 50%  
 Loss of a foot permanently severed at or above the ankle but below the knee ..... 50%  
 Loss of an arm permanently severed at or above the elbow ..... 75%  
 Loss of a leg permanently severed at or above the knee ..... 75%  
 Loss of sight in one eye..... 50%

**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as defined above..... 100%  
 Loss of the thumb and index finger of same hand ..... 25%

**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

**SCHEDULE OF BENEFITS (continued)**

|   |      |
|---|------|
| Loss of speech and loss of hearing..... | 100% |
| Loss of speech or loss of hearing ..... | 50%  |

**Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

|   |      |
|---|------|
| Paralysis of both arms and both legs .....                    | 100% |
| Paralysis of both legs .....                                  | 50%  |
| Paralysis of the arm and leg on either side of the body ..... | 50%  |
| Paralysis of one arm or leg.....                              | 25%  |

**Paralysis** means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

|                    |      |
|--------------------|------|
| Brain Damage ..... | 100% |
|--------------------|------|

**Brain Damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

|            |  |
|------------|--|
| Coma ..... | 1% monthly<br>beginning on the<br>7th day of the<br>Coma for the<br>duration of the<br>Coma to a<br>maximum of 60<br>months. |
|------------|--|

**Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

**Full Amount for Optional AD&D**

For Active Employees:

|                            |  |
|----------------------------|--|
| For Active Employees ..... | An amount equal to Your Optional Life Insurance. |
|----------------------------|--|

|  |             |
|--|-------------|
| Maximum Optional Accidental Death and Dismemberment Full Amount..... | \$2,500,000 |
|--|-------------|

**SCHEDULE OF BENEFITS (continued)****Additional Benefits:**

|                             |     |
|-----------------------------|-----|
| Seat Belt Benefit.....      | Yes |
| Air Bag Use Benefit.....    | Yes |
| Common Carrier Benefit..... | Yes |

**Schedule of Covered Losses for Optional Accidental Death and Dismemberment Insurance**

All amounts listed are stated as percentages of the Full Amount.

**Covered Losses**

|   |      |
|---|------|
| Loss of life .....  | 100% |
| Loss of a hand permanently severed at or above the wrist but below the elbow..... | 50%  |
| Loss of a foot permanently severed at or above the ankle but below the knee ..... | 50%  |
| Loss of an arm permanently severed at or above the elbow .....                    | 75%  |
| Loss of a leg permanently severed at or above the knee .....                      | 75%  |
| Loss of sight in one eye.....   | 50%  |

**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

|   |      |
|---|------|
| Loss of any combination of hand, foot, or sight of one eye, as defined above..... | 100% |
| Loss of the thumb and index finger of same hand .....                             | 25%  |

**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

|   |      |
|---|------|
| Loss of speech and loss of hearing..... | 100% |
| Loss of speech or loss of hearing ..... | 50%  |

**Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

|  |      |
|--|------|
| Paralysis of both arms and both legs ..... | 100% |
| Paralysis of both legs .....               | 50%  |

**SCHEDULE OF BENEFITS (continued)**

|   |     |
|---|-----|
| Paralysis of the arm and leg on either side of the body ..... | 50% |
| Paralysis of one arm or leg.....                              | 25% |

**Paralysis** means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

|                    |      |
|--------------------|------|
| Brain Damage ..... | 100% |
|--------------------|------|

**Brain Damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

|            |  |
|------------|--|
| Coma ..... | 1% monthly<br>beginning on the<br>7th day of the<br>Coma for the<br>duration of the<br>Coma to a<br>maximum of 60<br>months. |
|------------|--|

**Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

**SCHEDULE OF BENEFITS (continued)**

**If You Are Age 70 Or Older**

If You are age 70 or older on Your effective date of insurance, the appropriate percentage from the following table will be applied to the amount of Your Basic Life, and Accidental Death and Dismemberment insurance on Your effective date of insurance, adjusted for any later changes in Your salary.

If You are under age 70 on the effective date of Your insurance, the amount of Your Basic Life, and Accidental Death and Dismemberment insurance on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of Your insurance in effect on the day before Your 70<sup>th</sup> birthday, adjusted for any later changes in Your salary:

| <u>Age of Employee</u> | <u>Percentage</u> |
|------------------------|-------------------|
| 70 but less than 75    | 65%               |
| 75 or older            | 50%               |

**Life Insurance For Your Dependents**

For Active Employees:

|  |  |
|--|--|
| For Your Spouse.....                       | \$25,000   |
| Accelerated Benefit Option .....           | Up to 50% of Your Dependent Life amount not to exceed \$12,500 |
| For each of Your Children                  |  |
| From age 15 Days to 6 Months.....          | \$2,500  |
| From age 6 Months to 19 Years .....        | \$10,000   |
| Maximum Child Dependent Life Benefit ..... | \$10,000   |

## DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Basic Annual Earnings** means Your gross annual rate of pay as determined by Your Policyholder, excluding overtime and other extra pay. "Basic Annual Earnings" for You if You are a salesman includes commissions and/or bonuses which shall be averaged for the most recent 12 month period.

**Beneficiary** means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

**Child** means the following:

Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild who is:

- at least 15 days old, under age 19, unmarried and supported by You; or
- under age 25 and who is:
  - a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
  - unmarried;
  - supported by You; and
  - not employed on a full-time basis.

**Common Carrier** means a government regulated entity that is in the business of transporting fare paying passengers.

**The term does not include:**

- chartered or other privately arranged transportation;
- taxis; or
- limousines.

**Contributory Insurance** means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Optional Life Insurance, Optional Accidental Death and Dismemberment Insurance and Dependent Life Insurance.

**Dependent(s)** means Your Spouse and/or Child.

**Full-Time** means Active Work on the Policyholder's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 30 hours a week.

**GCERT2000**

**def**

## DEFINITIONS (continued)

**Hospital** means a facility which is licensed as such in the jurisdiction in which it is located and:

- provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of a staff of Physicians; and
- provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

**Hospitalized** means:

- admission for inpatient care in a Hospital;
- receipt of care in the following:
  - a hospice facility; or
  - an intermediate care facility; or
  - a long term care facility; or
- receipt of the following treatment, wherever performed:
  - chemotherapy; or
  - radiation therapy; or
  - dialysis.

**Noncontributory Insurance** means insurance for which the Policyholder does not require You to pay any part of the premium.

**Physician** means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

**The term does not include:**

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

**Proof** means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and

**DEFINITIONS (continued)**

- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Spouse** means Your lawful Spouse.

**The term does not include** any person who:

- is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada; or
- is insured under the Group Policy as an employee.

**We, Us** and **Our** mean MetLife.

**Written** or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**You** and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

### ELIGIBLE CLASS(ES)

#### **All Full-Time employees of the Policyholder.**

Senior Superior Judges, Judges, and All Other Eligible Employees

### DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for insurance described in this certificate on the later of:

1. May 1, 2005; and
2. the day after the date You complete the Waiting Period of 30 days.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

### Previous Employment With The Policyholder

If You were employed by the Policyholder and insured by Us under a policy of group life insurance when Your employment ended, You will not be eligible for life insurance under this Group Policy if You are re-hired by the Policyholder within 2 years after such employment ended, unless You surrender any individual policy of life insurance to which You converted when Your employment ended.

The cash value, if any, of such surrendered insurance will be paid to You.

### ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your Insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

### DATE YOUR INSURANCE TAKES EFFECT

#### **Rules for Noncontributory Insurance**

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work.

### DATE INSURANCE THAT IS NOT PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT FOR YOU

#### **Rules for Contributory Insurance**

If You request Contributory Insurance **before** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date. Accidental Death and Dismemberment Insurance does not require evidence of Your Insurability but such insurance will not take effect until the day Your Life Insurance takes effect.

If You request Contributory Insurance **within 31 days of** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such benefit will take effect on the later of:
  - the date You become eligible for such benefit; and
  - the date You enroll provided You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date. Accidental Death and Dismemberment Insurance does not require evidence of Your Insurability but such insurance will not take effect until the day Your Life Insurance takes effect.

If You request Contributory Insurance **more than 31 days after** the date You become eligible for such insurance, You must give evidence of Your insurability satisfactory to us. You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You complete the enrollment process for contributory Optional Accidental Death and Dismemberment Insurance **more than 31 days after** the date You become eligible for such insurance, Optional Accidental Death and Dismemberment Insurance does not require evidence of Your insurability, but will not take effect until the day Your Life Insurance takes effect.

### **Enrollment Due to a Qualifying Event**

You may enroll for insurance for which You are eligible or change the amount of Your insurance if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage
- the birth, adoption or placement for adoption of a dependent child
- divorce, legal separation or annulment
- the death of a dependent
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

### **Increase in Insurance**

An increase in insurance due to a change in class of employee, an increase in Your earnings, or a requested increase in insurance will take effect as follows:

- if You are **required** to give evidence of insurability for the entire increase in insurance and We approve Your evidence of insurability, the increase will take effect on the date We state in Writing. If We do not approve Your evidence of insurability, or You do not submit evidence of insurability, the increase in insurance will not take effect.
- if You are **not required** to give evidence of insurability, the increase will take effect on the date of Your request or the date of the increase in Your earnings.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

### **Decrease in Insurance**

A decrease in insurance due to a change in class of employee or a decrease in Your earnings will take effect on the date of change.

If You make a Written application to decrease Your insurance, that decrease will take effect as of the date of Your application.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. for Life Insurance, the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. for Life Insurance, the date You retire in accordance with the Policyholder's retirement plan; or
6. for Accidental Death and Dismemberment Insurance, the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
7. for Accidental Death and Dismemberment Insurance, the date You retire in accordance with the Policyholder's retirement plan.

Please refer to the section entitled LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED for information concerning continuation of Your Life Insurance if insurance ends while You are Totally Disabled. Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU for information concerning the option to convert to an individual policy of life insurance if Your Life Insurance ends.

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave and continuation for employees who choose portability.

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

### ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

#### All Full-Time employees of the Policyholder.

Active Employees

### DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. May 1, 2005;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the day after the date You complete the Waiting Period of 30 days.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

### ENROLLMENT PROCESS

If You are eligible for Dependent insurance, You may enroll for such insurance by completing an enrollment form for each Dependent to be insured. In addition, each of Your Dependents must give evidence of his insurability satisfactory to Us at Your expense if required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the Policyholder written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

### DATE INSURANCE THAT IS NOT PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT FOR YOUR DEPENDENTS

#### Rules for Contributory Dependent Insurance

##### For Dependents You Have When You Become Eligible For Dependent Insurance

If You complete the enrollment process for Dependent Life Insurance before the date You become eligible, such insurance will take effect for each enrolled Dependent on the date You become eligible, provided You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

##### For Dependents You Obtain After You Become Eligible For Dependent Insurance

If You obtain a Dependent after You become eligible for Dependent insurance, You may enroll the Dependent for such insurance **within 31 days** after the date he qualifies as a Dependent as defined in this certificate. The Dependent must give evidence of his insurability satisfactory to Us at Your expense if

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

required to do so under the section entitled Evidence of Insurability. The Dependent insurance for the Dependent will take effect as follows:

- if the Dependent is **not required** to give evidence of insurability, the insurance for those Dependents will take effect on the later of:
  - the date You become eligible for such insurance; and
  - the date You enroll;

provided You are Actively at Work on that date and the Additional Requirement stated below is satisfied; or

- if the Dependent is **required** to give evidence of insurability and We determine that all Dependents are insurable, the insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date and the Additional Requirement stated below is satisfied.

If You complete the enrollment process for any Dependent **more than 31 days after** the date he qualifies as a Dependent, the Dependent must give evidence of his insurability satisfactory to Us at Your expense. If We determine that the Dependent is insurable, the insurance will take effect on the date We state in Writing, if the Dependent satisfies the Additional Requirement stated below.

Once You have enrolled one Child for Dependent insurance, each succeeding Child will automatically be insured for such insurance on the date he qualifies as a Dependent.

If You are not Actively at Work on the date the Contributory Dependent Insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work and the Additional Requirement stated below is satisfied.

### Enrollment Due to a Qualifying Event

Under the rules of the flexible benefit plan, You may enroll for Dependent insurance for which You are eligible or change the amount of Your Dependent insurance between annual enrollment periods only if You have a Qualifying Event.

**Qualifying Event** includes:

- marriage
- birth, adoption or placement for adoption of a dependent child
- divorce, legal separation or annulment
- death of a dependent
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect for each enrolled Dependent as follows:

**ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

- if the Dependent is **not required** to give evidence of his insurability, such insurance will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.
- if the Dependent is **required** to give evidence of his insurability and We determine that the Dependent is insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date and the Dependent satisfies the Additional Requirement stated below.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Additional Requirement**

On the date the Dependent insurance is scheduled to take effect, the Dependent must not be:

- confined at home under a Physician's care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, insurance for the Dependent will take effect on the date he is no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

**DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS**

A Dependent's insurance will end on the earliest of:

1. for Dependent Life Insurance, the date all of the Life Insurance under the Group Policy ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the date the person ceases to be a Dependent;
7. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. for Dependent Life Insurance, the date You retire in accordance with the Policyholder's retirement plan; or
9. the end of the period for which the last premium has been paid for the Dependent.

Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS for information concerning the option to convert to an individual policy of life insurance if Life Insurance for a Dependent ends.

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the Date Insurance for Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) for continuation of insurance. Please contact the Policyholder for information regarding the FMLA.

### **AT YOUR OPTION: PORTABILITY**

#### **For Life and Accidental Death and Dismemberment Insurance**

For purposes of this subsection the term "Portability Eligible Insurance" refers to Optional Life and Optional Accidental Death and Dismemberment Insurance. If insurance for Your Dependents is in effect, the term "Portability Eligible Dependent Insurance" refers to Life Insurance For Your Dependents.

1. You may request in Writing during the Request Period specified below to continue Portability Eligible Insurance and Portability Eligible Dependent Insurance under another group policy if such insurance ends because:
  - Your employment ends; or
  - You cease to be in a class that is eligible for such insurance.
2. Your Dependent Spouse may request in Writing during the Request Period specified below to continue Portability Eligible Dependent Insurance on their life under another group policy if such insurance ends because:
  - You die; or
  - Your marriage ends in divorce or annulment.

If a request is made under this subsection, evidence of Your insurability will not be required. We will issue a new certificate of insurance which will explain the new insurance benefits. The insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

A request under this subsection may be made if, on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Policyholder of its intent to end the Group Policy;
- no application has been made to convert the insurance that is to be continued to an individual policy of life insurance as provided in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU or the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS; and
- the person making the request resides in a jurisdiction that permits portability.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

### **Request Period**

To continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance under a different group policy, We must receive a completed request form within the Request Period described below.

If written notice of the option to continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance is given within 15 days before or after the date such insurance ends, the Request Period begins on the date the insurance ends and expires 31 days after such date.

If written notice of the option to continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance is given more than 15 days after but within 90 days of the date such insurance ends, the Request Period begins on the date the insurance ends and expires 45 days after the date of the notice.

If written notice of the option to continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance is not given within 90 days after the date such insurance ends, the Request Period begins on the date the insurance ends and expires at the end of such 90 day period.

### **Amount of the New Certificate**

The maximum amount of Optional Life Insurance that may be continued is the lesser of:

- the total amount of all such insurance in effect immediately prior to the date it ends; and
- for residents of all states other than Michigan the maximum amount is \$1,000,000. For residents of Michigan, the maximum amount is limited by law and effective July 1, 2004 the maximum amount is \$169,000.

The minimum amount of Optional Life Insurance that may be continued is \$20,000.

The maximum Full Amount of Accidental Death and Dismemberment Insurance that may be continued is the lesser of:

- the Full Amount of such insurance in effect immediately prior to the date it ends; and
- for residents of all states other than Michigan the maximum amount is \$1,000,000. For residents of Michigan, the maximum amount is limited by law and effective July 1, 2004 the maximum amount is \$169,000.

The minimum Full Amount of Accidental Death and Dismemberment Insurance that may be continued is \$20,000.

The maximum amount of Life Insurance for Your Dependents that may be continued is:

- if You are making the request to continue such insurance, the lesser of:
  - the amount of such insurance in effect immediately prior to the date it ends; and,
  - the amount of such Portability Eligible Insurance which is being continued on Your life.
- if Your Dependent is making the request to continue such insurance, the amount of such insurance in effect immediately prior to the date it ends.

### **Premiums for the New Certificate**

When a request to continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance is made under this subsection, the first premium must be paid during the Request Period. All premium payments must be made directly to Us. When We issue the new certificate, We will also provide a schedule of premiums and payment instructions.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

### **Right to Convert Life Insurance Amounts Not Continued**

Any amount of Life Insurance not continued under this subsection may be converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU or the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS.

### **If You Die Within 31 Days of the Date Portability Eligible Insurance Ends**

If You die within 31 days of the date Portability Eligible Insurance ends and an application for a new certificate is not received by Us during such period, We will determine whether to pay insurance in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. If an application for a new certificate was received by Us during such period, We will only pay benefits for the Portability Eligible Insurance applied for in accordance with this subsection.

### **If a Dependent Dies Within 31 Days of the Date Portability Eligible Dependent Insurance Ends**

If a Dependent dies within 31 days of the date Portability Eligible Dependent Insurance ends and an application for a new certificate is not received by Us during such period, We will determine whether to pay insurance in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS. If an application for a new certificate was received by Us during the such period, We will only pay benefits for the Portability Eligible Dependent Insurance applied for in accordance with this subsection.

### **If You are Totally Disabled on the Date Your Employment Ends**

If You are Totally Disabled on the date Your employment ends and You elect to continue Portability Eligible Insurance and/or Portability Eligible Dependent Insurance as provided in this subsection, You may at a later date become approved for continuation of insurance under the section entitled LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED. If You are so approved, any insurance continued under this subsection or any new certificate provided under this subsection will end and We will return any premium paid by You for such insurance.

## **AT THE POLICYHOLDER'S OPTION**

The Policyholder has elected to continue insurance by paying premiums for his employees who cease Active Work in an eligible class for any of the reasons specified below;

1. if You cease Active Work due to injury or sickness contact the Policyholder to determine if Your insurance can be continued and for how long;
2. if You cease Active Work due to strike contact the Policyholder to determine if Your insurance can be continued and for how long;
3. if You cease Active Work due to layoff contact the Policyholder to determine if Your insurance can be continued and for how long;
4. if You cease Active Work due to any other Policyholder approved leave of absence discuss with the Policyholder at the time You receive approval to take the leave of absence whether Your insurance can be continued and for how long.

However, the period for layoff and leave of absence will not continue beyond 2 months after the date the period begins.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;

**CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the Date Your Insurance Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

## EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. in order to become covered for an amount of Basic Life Insurance greater than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS.  
If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Basic Life Insurance will be limited to the Non-Medical Issue Amount.
2. in order for You to increase the amount of Your Basic Life Insurance.  
If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Basic Life Insurance will not be increased.
3. in order to become covered for a total amount of Life Insurance greater than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS.  
If You do not give Us evidence of Your insurability, or if such evidence of insurability is not accepted by Us as satisfactory, the amount of Your Life Insurance will be equal to the Non-Medical Issue Amount.
4. in order to receive an increase in the amount of Your Optional Life Insurance over the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS due to an increase in Your Basic Annual Earnings.  
If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the increase in Your Life Insurance will be limited to the Non-Medical Issue Amount.
5. if You make a request within **31 days of a Qualifying Event** to increase the amount of Your Optional Life Insurance.  
if You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of your Optional Life Insurance will not be increased.
6. if You make a late request for Optional Life Insurance. A late request is one made more than 31 days after You become eligible.  
If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Optional Life Insurance.
7. if You make a late request for Life Insurance for Your Dependents. A late request is one made more than 31 days after Your Dependent becomes eligible.  
If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, Your Dependents will not be covered for Life Insurance.

The evidence of insurability is to be given at Your expense.

**LIFE INSURANCE: FOR YOU**

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

**PAYMENT OPTIONS**

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

**LIFE INSURANCE: FOR YOUR DEPENDENTS**

If a Dependent dies, Proof of the Dependent's death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the life of such Dependent on the date of death.

**PAYMENT OPTIONS**

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

## **LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU**

For purposes of this section, the term “ABO Eligible Life Insurance” refers to each of Your Life Insurance benefits for which the Accelerated Benefit Option is shown as available in the SCHEDULE OF BENEFITS.

If You become Terminally Ill, You or Your legal representative have the option to request Us to pay ABO Eligible Life Insurance before Your death. This is called an accelerated benefit. The request must be made while ABO Eligible Life Insurance is in effect.

**Terminally Ill or Terminal Illness** means that due to injury or sickness, You are expected to die within 6 months.

### **Requirements For Payment of an Accelerated Benefit**

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of each ABO Eligible Life Insurance benefit to be accelerated equals or exceeds \$10,000; and
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that You are Terminally Ill.

We will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once.

### **Proof of Your Terminal Illness**

We will require the following Proof of Your Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician’s certification that You are Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

### **Accelerated Benefit Amount**

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for each ABO Eligible Life Insurance benefit in effect for You, subject to the following:

**Maximum Accelerated Benefit Amount.** The maximum amount We will pay for each ABO Eligible Life Insurance benefit is shown in the SCHEDULE OF BENEFITS.

**Interest and expense charge.** We will decrease the amount of the accelerated benefit We will pay by a discount for the mortality and interest for the actuarially determined life span which includes an administrative charge. This discount is referred to as the Interest and Expense Charge.

The maximum interest rate We will use will be the then current maximum adjustable policy loan interest rate based on Moody’s Corporate Bond Yield Averages - Monthly Corporate Averages, published by Moody’s Investors Service, Inc. or its successor for the calendar month ending 2 months before the date that You or Your legal representative request an accelerated benefit.

**Scheduled Reduction of an ABO Eligible Life Insurance Benefit.** If an ABO Eligible Life Insurance benefit is scheduled to reduce within the 6 month period after the date You or Your legal

## **LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU (continued)**

representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of such ABO Eligible Life Insurance that will be in effect immediately after the reduction(s) scheduled for such period.

**Scheduled End of an ABO Eligible Life Insurance Benefit.** If an ABO Eligible Life Insurance benefit is scheduled to end within 6 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit for such ABO Eligible Life Insurance benefit.

**Previous Conversion of an ABO Eligible Life Insurance Benefit.** We will not pay an accelerated benefit for any amount of ABO Eligible Life Insurance which You previously converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

### **Effect of Payment of an Accelerated Benefit**

**On premium for Your Life Insurance.** After We pay the accelerated benefit, any premium You are required to pay will be based upon the amount of Your Life Insurance remaining after the accelerated benefit is paid.

**On Your Life Insurance at Your death.** The amount of Life Insurance that We will pay at Your death will be decreased by:

- the amount of the accelerated benefit paid by Us; and
- the Interest and Expense Charge.

**On Your Life Insurance at conversion.** The amount to which You are entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU, will be decreased by:

- the amount of the accelerated benefit paid by Us; and
- the Interest and Expense Charge.

**On Your Accidental Death and Dismemberment Insurance.** Payment of an accelerated benefit will not affect Your Accidental Death and Dismemberment Insurance.

### **Date Your Option to Accelerate Benefits Ends**

The accelerated benefit option will end on the earliest of:

- the date that is 2 years prior to Your normal date of retirement;
- the date the ABO Eligible Life Insurance ends;
- the date You or Your legal representative assign all ABO Eligible Life Insurance; or
- the date You or Your legal representative have accelerated all ABO Eligible Life Insurance benefits.

## LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOUR SPOUSE

If Your Spouse becomes Terminally Ill, You or Your legal representative have the option to request Us to pay Life Insurance for Your Spouse before his death. This is called an accelerated benefit. The request must be made while Life Insurance for Your Spouse is in effect.

**Terminally Ill or Terminal Illness** means that due to injury or sickness, Your Spouse is expected to die within 6 months.

### Requirements For Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of Life Insurance for the Terminally Ill Spouse equals or exceeds \$10,000; and
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that Your Spouse is Terminally Ill.

We will only pay an accelerated benefit for Life Insurance for Your Spouse once.

### Proof of Your Spouse's Terminal Illness

We will require the following Proof of Your Spouse's Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician's certification that Your Spouse is Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

### Accelerated Benefit Amount

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for the amount of Life Insurance in effect for a Terminally Ill Spouse, subject to the following:

**Maximum Accelerated Benefit Amount.** The maximum amount We will pay is shown in the SCHEDULE OF BENEFITS.

**Interest and Expense Charge.** We will decrease the amount of the accelerated benefit We will pay by a discount for the mortality and interest for the actuarially determined life span which includes an administrative charge. This discount is referred to as the Interest and Expense Charge.

The maximum interest rate We will use will be the then maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages - Monthly Corporate Averages, published by Moody's Investors Service, Inc. or its successor for the calendar month ending 2 months before the date that You or Your legal representative request an accelerated benefit.

**Scheduled reduction of Life Insurance for a Terminally Ill Spouse.** If the Life Insurance in effect for a Terminally Ill Spouse is scheduled to reduce within the 6 month period after the date You or Your legal representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of Life Insurance that will be in effect for Your Spouse immediately after the reduction(s) scheduled for such period.

## **LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOUR SPOUSE (continued)**

**Scheduled end of Life Insurance for a Terminally Ill Spouse.** If the Life Insurance in effect for a Terminally Ill Spouse is scheduled to end within 6 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

### **Effect of Payment of an Accelerated Benefit**

**On Premium for Life Insurance.** Any premium You are required to pay for Life Insurance for Your Spouse for whom We paid an accelerated benefit will be based upon the amount of Life Insurance for Your Spouse remaining after payment of the accelerated benefit.

**On Payment of Life Insurance at a Dependent's death.** The amount of Life Insurance that We will pay at death of Your Spouse for whom We paid an accelerated benefit will be decreased by:

- the amount of the accelerated benefit paid by Us for such Dependent; and
- the Interest and Expense Charge.

**On Life Insurance at conversion.** The amount to which Your Spouse for whom We paid an accelerated benefit is entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS provision will be decreased by:

- the amount of the accelerated benefit paid by Us for Your Spouse; and
- the Interest and Expense Charge.

### **Date Your Option to Accelerate Benefits Ends**

The accelerated benefit option for Your Spouse will end on the earliest of:

- the date Life Insurance for Your Spouse ends;
- the date Your rights in Life Insurance for Your Spouse are assigned; or
- the date You or Your legal representative have accelerated all Dependent Life Insurance benefits.

## **LIFE INSURANCE: CONVERSION OPTION FOR YOU**

If Your Life Insurance ends for any of the reasons stated below, You have the option to buy an individual policy of life insurance (“new policy”) from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the “option to convert”. Evidence of Your insurability will not be required.

### **When You Will Have the Option to Convert**

You will have the option to convert when:

- Your Life Insurance ends because:
  - You cease to be in an eligible class;
  - Your employment ends;
  - the Group Policy ends, provided You have been insured for Life Insurance for at least 5 years; or
  - the Group Policy is amended to end Life Insurance for an eligible class of which You are a member, provided You have been insured for Life Insurance for at least 5 years.

A reduction in the amount of Your Life Insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

### **Application Period**

If You opt to convert Your Life Insurance for any of the reasons stated above, We must receive a completed conversion application form from You within 31 days after the date Your Life Insurance ends.

### **Option Conditions**

The option to convert is subject to these conditions:

1. Our receipt within the Application Period of:
  - Your Written application for the new policy; and
  - the premium due for such new policy;
2. the premium rates for the new policy will be based on:
  - Our rates then in use;
  - the form and amount of insurance;
  - Your class of risk; and
  - Your attained age when Your Life Insurance ends;
3. the new policy may be on any form then customarily offered by Us excluding term insurance;
4. the new policy will be issued without an accidental death and dismemberment benefit, a continuation benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and
5. the new policy will take effect on the 32<sup>nd</sup> day after the date Your Life Insurance ends; this will be the case regardless of the duration of the Application Period.

### **Maximum Amount of the New Policy**

If Your Life Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end Life Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may elect for the new policy is the lesser of:

- the amount of Your Life Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or

**LIFE INSURANCE: CONVERSION OPTION FOR YOU (continued)**

- \$2,000.

If Your Life Insurance ends for any other reason the maximum amount of insurance that You may elect for the new policy is the amount of Your Life Insurance which ends under the Group Policy.

**If You Die Within 31 Days After Your Life Insurance Ends**

If You die within 31 days after Your Life Insurance ends, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary the amount of Life Insurance You were entitled to convert.

**Effect of Previous Conversion**

If You obtained a new policy under this conversion option because Your Life Insurance ended and such insurance is later continued under the section entitled LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED, We will only pay Your Life Insurance under such section if the new policy is returned to Us. If the new policy is returned to Us, We will refund to Your estate the premium paid for such policy without interest, less any debt incurred under such policy. If the new policy is not returned to Us, We will only pay the life insurance in effect under such new policy.

We will not pay insurance under both the Group Policy and such new policy.

## **LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS**

If Life Insurance for a Dependent ends for any of the reasons stated below, You or the Dependent will have the option to buy from Us an individual policy of life insurance on the life of the Dependent (“new policy”) during the Application Period in accordance with the conditions and requirements of this section. This is referred to as “the option to convert”. Evidence of the Dependent’s insurability will not be required.

### **When You or a Dependent Will Have the Option to Convert**

You will have the option to convert Life Insurance for a Dependent when:

- Life Insurance for the Dependent ends because:
  - You cease to be in an eligible class;
  - Your employment ends;
  - the Group Policy ends, provided You have been insured for Life Insurance for the Dependent for at least 5 years;
  - the Group Policy is amended to end Life Insurance for Dependents for an eligible class of which You are a member, provided You have been insured for Life Insurance for the Dependent for at least 5 years.

A Dependent will have the option to convert when Life Insurance ends because such Dependent ceases to qualify as a Dependent as defined in this certificate.

A reduction in the amount of Life Insurance for a Dependent as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

You must notify the Policyholder in the event that a Dependent ceases to qualify as a Dependent as defined in this certificate.

### **Application Period**

If You or a Dependent opt to convert as stated above, We must receive a completed conversion application form within 31 days of the date Life Insurance for the Dependent ends.

### **Option Conditions**

The option to convert is subject to these conditions:

1. Our receipt within the Application Period of:
  - a Written application for the new policy for the Dependent; and
  - the premium due for such new policy;
2. the premium rates for the new policy will be based on:
  - Our rates then in use;
  - the form and amount of insurance;
  - the Dependent’s class of risk; and
  - the Dependent’s attained age when Life Insurance for such Dependent ends;
3. the new policy may be on any form then customarily offered by Us excluding term insurance;
4. the new policy will be issued without an accidental death and dismemberment benefit, a continuation benefit, an accelerated benefit option, waiver of premium benefit or any other rider or additional benefit; and
5. the new policy will take effect on the 32<sup>nd</sup> day after the date Life Insurance for the Dependent ends; this will be the case regardless of the duration of the Application Period.

### **Maximum Amount of the New Policy**

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**LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS (continued)**

If Life Insurance for a Dependent ends due to the end of the Group Policy or the amendment of the Group Policy to end Life Insurance for Dependents for an eligible class of which You are a member, the maximum amount of insurance that may be elected for the new policy is the lesser of:

- the amount of Life Insurance for the Dependent that ends under the Group Policy less the amount of Life Insurance for Dependents for which You become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or
- \$2,000.

If Life Insurance for a Dependent ends for any other reason the maximum amount of insurance that may be elected for the new policy is the amount of Life Insurance for the Dependent that ends under the Group Policy.

**If a Dependent Dies Within the 31 Days After Life Insurance for a Dependent Ends**

If a Dependent dies within 31 days after the date Life Insurance for the Dependent ends, Proof of the Dependent's death must be sent to Us. When we receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary the amount of Life Insurance for the Dependent that could have been converted.

## **LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED**

If Your Life Insurance ends while You are Totally Disabled, You may at a later date become eligible to continue certain Life Insurance under this section during the period You are Totally Disabled. Premium payment will not be required. We will determine Your eligibility for this continuation after We receive Proof that You have satisfied the conditions and requirements of this section.

For the purpose of this section, the Life Insurance that You may become eligible to continue (“Continuation Eligible Life Insurance”) refers to:

- Basic Life Insurance; and
- Optional Life Insurance, if You were insured for 12 months before Total Disability began;

to the extent that such insurance was in effect for You on the date Your Continuation Eligible Life Insurance ended.

Continuation Eligible Life Insurance does not include Life Insurance amounts accelerated under the section entitled LIFE INSURANCE: ACCELERATED BENEFIT OPTION FOR YOU.

Continuation Eligible Life Insurance may be reduced during the continuation period on account of Your age or as otherwise described in this certificate.

Total Disability must begin before You attain age 60 and while You are insured for Continuation Eligible Life Insurance.

**Total Disability or Totally Disabled** means that due to an injury or sickness:

- You are unable to perform the material duties of Your regular job; and
- You are unable to perform any other job for which You are fit by education, training or experience.

### **TOTAL DISABILITY AND PROOF REQUIREMENTS**

You will become eligible for this continuation if Your Total Disability continues without interruption from the date You become Totally Disabled through the end of the Continuation Waiting Period.

**Continuation Waiting Period** means the period which begins on the date You become Totally Disabled and which expires 9 consecutive months after such date.

Please refer to the Important Notice that appears at the end of this section for information on insurance during the Continuation Waiting Period.

If You were disabled when Your insurance ended, You should contact Us as soon as reasonably possible to advise Us that You were disabled on the date such insurance ended. After the Continuation Waiting Period expires, You must send Us Proof that You were Totally Disabled when Your Continuation Eligible Life Insurance ended and that such Total Disability has continued without interruption through the expiration of the Continuation Waiting Period. You must do this within 3 months following the expiration of the Continuation Waiting Period.

As part of such Proof, We may choose a Physician to examine You to verify that You are eligible for this continuation. If We do so, We will pay for such exam. After We receive and review Your Proof, We will determine if You are approved for this continuation. We will send You Written notice advising whether You are approved.

To verify that You continue to be Totally Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Totally Disabled. We will not ask for such Proof more than once each year.

## **LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED (continued)**

### **DATE CONTINUATION ENDS**

The Continuation Eligible Life Insurance continued under this section will end at the earliest of:

1. the date You die;
2. the date Your Total Disability ends;
3. the date You do not give Us Proof of Total Disability, as required;
4. the date You refuse to be examined by Our Physician, as required; or
5. the date You attain age 65.

### **OPTION TO CONVERT YOUR CONTINUATION ELIGIBLE LIFE INSURANCE**

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the conversion option described in such section if:

- before the end of the Application Period for conversion You return to Active Work in an eligible class and become insured under the Group Policy; or
- You have already converted all of Your Continuation Eligible Life Insurance under such section.

### **IF YOU DIE DURING CONTINUATION**

If You die while Your Continuation Eligible Life Insurance is being continued under this section, Proof of Your death must be sent to Us within one year of Your death. Proof includes supporting documentation that Total Disability continued with no interruption from the date Your Life Insurance ended until the date of Your death.

When we receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary the Continuation Eligible Life Insurance continued under this section.

### **Effect of Previous Conversion**

If You converted Your Continuation Eligible Life Insurance to an individual policy, We will only pay the Continuation Eligible Life Insurance under this section if such individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If You do not return such individual policy to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

### **IMPORTANT NOTICE**

On the date Your insurance ends, We will not know whether You will be able to satisfy the Total Disability and Proof Requirements specified above. For this reason, We urge You to consider taking the following steps:

**Step 1.** When Your Continuation Eligible Life Insurance ends, ask the Policyholder if such insurance will be continued with premium payment. If the answer is yes, ask if such continuation will be for at least 12 months. If the answer is yes, file a claim for continuation of insurance under this section at the end of the Continuation Waiting Period.

If the Policyholder will not continue Your Continuation Eligible Life Insurance as described in Step 1, proceed to Step 2.

**LIFE INSURANCE: ELIGIBILITY FOR CONTINUATION IF LIFE INSURANCE ENDS WHILE YOU ARE TOTALLY DISABLED (continued)**

**Step 2.** Read the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. You have the option to convert Your Continuation Eligible Life Insurance to an individual policy of insurance with premium payment.

If the Policyholder will not continue Your Continuation Eligible Life Insurance as described in Step 1 and You do not convert to an individual policy as described in Step 2:

- You will not be insured should You die during the Continuation Waiting Period; and
- You may not be eligible to convert Your Continuation Eligible Life Insurance at the end of the Continuation Waiting Period if We do not approve You for the continuation under this section.

## ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, will pay the insurance in effect on the date of the injury.

**Direct and Sole Cause** means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

### PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

### EXCLUSIONS

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority, except the United States National Guard;
6. any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician, or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

- poison, gas, or fumes; or

9. war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

**Exclusion for Intoxication**

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

**Intoxicated** means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

**BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

**APPLICABILITY OF PROVISIONS**

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: SEAT BELT USE**

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
  - was in an accident while driving or riding as a passenger in a Passenger Car;
  - was wearing a Seat Belt which was properly fastened at the time of the accident; and
  - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

**Passenger Car** means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

**Seat Belt** means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

**The term includes** any child restraint device that meets the requirements of state law.

### **BENEFIT AMOUNT**

The Seat Belt Use benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than \$1,000 or more than \$25,000.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: AIR BAG USE**

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
  - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
  - was riding in a seat protected by an Air Bag;
  - was wearing a Seat Belt which was properly fastened at the time of the accident; and
  - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

**Passenger Car** means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

**Seat Belt** means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

**The term includes** any child restraint device that meets the requirements of state law.

**Air Bag** means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

### **BENEFIT AMOUNT**

The Air Bag Use Benefit is an additional benefit equal to 5% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than \$1,000 or more than \$10,000.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

**ADDITIONAL BENEFIT: COMMON CARRIER**

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

**BENEFIT AMOUNT**

The Common Carrier Benefit is an amount equal to the Full Amount shown in the SCHEDULE OF BENEFITS.

**BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

## FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

### CLAIMS FOR LIFE INSURANCE BENEFITS

**When a claimant files a claim for Life Insurance benefits**, Proof should be sent to Us as soon as is reasonably possible after the death of an insured.

### CLAIMS FOR OTHER INSURANCE BENEFITS

**When a claimant files a claim for any other insurance benefits described in this certificate**, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

Notice of claim and Proof may also be given to Us by following the steps set forth below:

#### Step 1

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

#### Step 2

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

#### Step 3

When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

#### Step 4

The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

**Time Limit on Legal Actions.** A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

## GENERAL PROVISIONS

### Assignment

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment as described below. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift. We will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You and the assignee(s);
3. the Policyholder acknowledges that Your Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and
4. the Written form is delivered to Us for recording.

You may have made an irrevocable assignment under a group policy that the Group Policy replaces. In this case, We will recognize the assignee(s) under such assignment as owners of Your right, title and interest under the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You, the assignee(s) and the Policyholder; and
3. the Written form is delivered to Us for recording.

### Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving Beneficiary at Your death, We may determine the Beneficiary to be one or more of the following who survive You:

1. Your Spouse;
2. Your child(ren);
3. Your parent(s); or
4. Your sibling(s).

Instead of making payment to any of the above, we may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

For Your Life Insurance for Your Dependents, We may pay You as the Beneficiary, if alive. If You are not alive, We may determine the Beneficiary to be one or more of the following who survive You:

## **GENERAL PROVISIONS (continued)**

1. Your Spouse;
2. Your child(ren);
3. Your parent(s); or
4. Your sibling(s).

Instead of making payment to any of the above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment.

If You and any Dependent die within a 24 hour period, We will pay the Dependent's Life Insurance to the Beneficiary receiving payment of Your Life Insurance or, We will pay Your estate. If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

### **Suicide**

#### **For Optional Life**

**If You commit suicide within 2 years** from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 2 years from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

#### **For Dependent Life**

**If a Dependent commits suicide within 2 years** from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 2 years from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to contest life insurance, reduce benefits or defend a claim unless the following requirements are met:

**GENERAL PROVISIONS (continued)**

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, we will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

**Misstatement of Age**

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

**Conformity with Law**

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

**Physical Exams**

If a claim is submitted for insurance benefits other than life insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

**Autopsy**

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Attachment 5  
Cobb County Basic Life Amount

| COBB COUNTY LIFE INSURANCE BENEFITS FOR JUDGES  |  |  |  |  |        |     |        |          |         |                |                          |          |                                      |           |          |
|---|--|--|--|--|--------|-----|--------|----------|---------|----------------|--------------------------|----------|--------------------------------------|-----------|----------|
| SUPERIOR COURT JUDGES   |  |  |  |  |        |     |        |          |         |                |                          |          |                                      |           |          |
|   |  |  |  |  | gender | age | salary | location | dept no | department     | title                    | location | life_summary                         | life_code | life_ben |
|   |  |  |  |  | M      | 59  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | M      | 56  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | F      | 64  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | F      | 55  | 58711  | 9521     | 225     | Superior Court | CHIEF JUDGE SUPERIOR CO  | 951000   | State 116,750 + County 58,711+ 9,800 | LIFEC     | 186,000  |
|   |  |  |  |  | M      | 47  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | M      | 67  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | M      | 69  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 951000   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | F      | 71  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
|   |  |  |  |  | M      | 57  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LFJUD     | 176,000  |
|   |  |  |  |  | F      | 55  | 58711  | 9521     | 225     | Superior Court | JUDGE SUPERIOR COURT     | 952100   | State 116,750 + County 58,711        | LIFEJ     | 176,000  |
| Superior Court Judge Benefit: 1 X Basic Annual Earnings (State and County) rounded to the next higher \$1,000 |  |  |  |  |        |     |        |          |         |                |                          |          |                                      |           |          |
| STATE COURT JUDGES  |  |  |  |  |        |     |        |          |         |                |                          |          |                                      |           |          |
|   |  |  |  |  | gender | age | salary | location | dept no | department     | title                    | location | life_summary                         | life_code | life_ben |
|   |  |  |  |  | M      | 59  | 160906 | 9450     | 220     | State Court    | CHIEF JUDGE STATE COUR   | 945000   | Employee Coverage - \$322,000        | LFJUD     | 314000   |
|   |  |  |  |  | F      | 55  | 156954 | 9435     | 220     | State Court    | JUDGE STATE COURT        | 943500   | Employee Coverage - \$314,000        | LIFE      | 314000   |
|   |  |  |  |  | F      | 63  | 156954 | 9490     | 220     | State Court    | JUDGE STATE COURT        | 949000   | Employee Coverage - \$314,000        | LFJUD     | 314000   |
|   |  |  |  |  | M      | 50  | 156954 | 9480     | 220     | State Court    | JUDGE STATE COURT        | 948000   | Employee Coverage - \$314,000        | LFJPO     | 314000   |
|   |  |  |  |  | F      | 67  | 156954 | 9460     | 220     | State Court    | JUDGE STATE COURT        | 946000   | Employee Coverage - \$314,000        | LFJUD     | 314000   |
|   |  |  |  |  | M      | 62  | 156954 | 9470     | 220     | State Court    | JUDGE STATE COURT        | 947000   | Employee Coverage - \$314,000        | LFJUD     | 314000   |
|   |  |  |  |  | F      | 56  | 156954 | 9475     | 220     | State Court    | JUDGE STATE COURT        | 947500   | Employee Coverage - \$314,000        | LFJPO     | 314000   |
|   |  |  |  |  | M      | 44  | 134454 | 9006     | 200     | State Court    | JUDGE STATE COURT DIV II | 900200   | Employee Coverage - \$269,000        |           | 269000   |
|   |  |  |  |  | F      | 48  | 134454 | 9005     | 200     | State Court    | JUDGE STATE COURT DIV II | 900200   | Employee Coverage - \$269,000        |           | 269000   |
|   |  |  |  |  | M      | 54  | 134454 | 9003     | 200     | State Court    | JUDGE STATE COURT DIV II | 900200   | Employee Coverage - \$269,000        |           | 269000   |
|   |  |  |  |  | F      | 44  | 134454 | 9004     | 200     | State Court    | JUDGE STATE COURT DIV II | 900200   | Employee Coverage - \$269,000        |           | 269000   |

