

---

---

**GROUP  
BENEFIT  
PLAN**

**CALIFORNIA LONG-TERM DISABILITY SAMPLE CONTRACT**



---

**TABLE OF CONTENTS**

---

**Group Long Term Disability Benefits**

	PAGE
CERTIFICATE OF INSURANCE.....	1
SCHEDULE OF INSURANCE .....	1
Must you contribute toward the cost of coverage?.....	1
Who is eligible for coverage?.....	1
When will You become eligible? (Eligibility Waiting Period) .....	1
ELIGIBILITY AND ENROLLMENT .....	5
When does your coverage start?.....	6
When will coverage become effective if a disabling condition causes you to be absent from work on the date it is to start? .....	6
Can you change benefit options?.....	6
When will a requested change in benefit options take effect?.....	6
BENEFITS .....	7
When do benefits become payable? .....	7
When will benefit payments terminate? .....	8
What happens if You return to work but become Disabled again? .....	8
CALCULATION OF MONTHLY BENEFIT.....	9
Family Care Credit Benefit .....	10
Survivor Income Benefit .....	11
Workplace Modification Benefit.....	11
PRE-EXISTING CONDITIONS LIMITATIONS .....	12
Are there any other limitations on coverage?.....	12
EXCLUSIONS .....	13
What Disabilities are not covered?.....	13
TERMINATION .....	13
When does your coverage terminate?.....	13
Does your coverage continue if your employment terminates because you are Disabled?.....	14
GENERAL PROVISIONS .....	14
DEFINITIONS .....	16
ERISA .....	21

PS-M-90

**INSURER INFORMATION NOTICE**

**NOTICE REQUIREMENT**

**IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT:**

**STATE OF CALIFORNIA INSURANCE DEPARTMENT  
CONSUMER COMMUNICATIONS BUREAU  
300 SOUTH STREET, SOUTH TOWER  
LOS ANGELES, CA 90013**

**1-800-927-HELP**

**THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS:**

**THE HARTFORD GROUP BENEFIT'S DIVISION  
POLICYHOLDER SERVICES, P.O. BOX 2999  
HARTFORD, CT 06104-2999  
TELEPHONE: 1-800-572-9047**



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
Hartford, Connecticut  
(Herein called Hartford Life)

---

**CERTIFICATE OF INSURANCE**  
Under  
**The Group Insurance Policy**  
**as of the Effective Date**  
Issued by  
**HARTFORD LIFE**  
to  
**The Policyholder**

---

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employee of the Policyholder who is named below and who:

- is eligible for the insurance;
  - becomes insured; and
  - continues to be insured;
- according to the terms of the Policy.

EMPLOYEE NAME: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

**Richard G. Costello, Secretary**

**Thomas M. Marra, President**

**SCHEDULE OF INSURANCE**

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder: ABC COMPANY  
Group Insurance Policy: GLT-123456  
Plan Effective Date: April 1, 2008

This plan of Long Term Disability Insurance provides You with long term income protection if You become Disabled from a covered injury, sickness, Mental Illness, Substance Abuse or pregnancy. Where used in this contract, the term Disabled or Disability shall mean Total Disability or Partial Disability as defined in the Definitions Section of the Certificate.

**Must you contribute toward the cost of coverage?**

You [must/do not] contribute toward the cost of coverage.

**Who is eligible for coverage?**

Eligible Class(es): [All Active Full-time Employees who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees]

Full-time Employees: [30] hours weekly

**Maximum Monthly Benefit:** [\$8,000]

[The **Minimum Monthly Benefit** will be the greater of:

- \$100; or
- 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.]

**Benefit Percentage:** [60%]

[**Annual Enrollment Period:** Determined by your Employer on a yearly basis]

**When will You become eligible? (Eligibility Waiting Period)**

You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

**The Elimination Period** is the period of time you must be Disabled before benefits become payable. It is the last to be satisfied of the following:

1. the first[ 180] consecutive day(s) of any one period of Disability; or
2. with the exception of benefits required by state law, the expiration of any Employer sponsored short term disability benefits or salary continuation program.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**[MAXIMUM DURATION OF BENEFITS TABLE**

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

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

<b>Year of Birth</b>	<b>Normal Retirement Age</b>
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

The above table shows the maximum duration for which benefits may be paid. All other limitations of the plan will apply.]

**ELIGIBILITY AND ENROLLMENT**

**Who are Eligible Persons?**

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

**When will you become eligible?**

You will become eligible for coverage on either:

1. the Plan Effective Date, if you have completed the Eligibility Waiting Period; or if not
2. the date on which you complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**[How do you enroll?**

To enroll you must:

1. complete and sign a group insurance enrollment form which is satisfactory to us; and
2. deliver it to the Employer.

If you do not enroll within 31 days after becoming eligible, the following limitations will apply to a later enrollment:

1. you must submit Evidence of Insurability satisfactory to us; and
2. you may not enroll until:
  - a) an Annual Enrollment Period; or
  - b) you have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 31 days of the Change in Family Status.

The dates of the Annual Enrollment Period are shown in the Schedule of Insurance.]

**[What constitutes a Change in Family Status?**

A Change in Family Status means:

1. your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child; or
2. the death of or divorce from your spouse; or
3. the death of or emancipation of a child.]

**[What is Evidence of Insurability?**

If you are required to submit Evidence of Insurability, you must:

1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at your own expense.

We will then determine if you are insurable under the plan.]

**WHEN COVERAGE STARTS**

**When does your coverage start?**

If you are not required to contribute toward the plan's cost, [ for benefit amounts not requiring Evidence of Insurability,] your coverage will start on the date you become eligible. [For benefit amounts requiring satisfactory Evidence of Insurability, your coverage will start on the date we approve such evidence.]

**DEFERRED EFFECTIVE DATE**

**When will coverage become effective if a disabling condition causes you to be absent from work on the date it is to start?**

If you are absent from work due to:

1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

on the date your insurance or increase in coverage would otherwise have become effective, your effective date will be deferred. Your insurance, or increase in coverage will not become effective until you are Actively at Work for one full day.

## CHANGES IN COVERAGE

### **[When will a requested change in benefit options take effect?**

If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

1. the first day of the month following the Annual Enrollment Period; or
2. the date we approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of:

1. the date You enroll for the change; or
2. the date we approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

Any such increase in coverage is subject to the Deferred Effective Date Provision. ]

### **Do coverage amounts change if there is a change in Your class or Your rate of pay?**

Your coverage may increase or decrease on the date there is a change in Your class or Monthly Rate of Basic Earnings. However, no increase in coverage will be effective unless on that date You:

1. are an Active Full-time Employee; and
2. are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Rate of Basic Earnings will become effective until the date we receive notice of the change.

### **What happens if the Employer changes the plan?**

Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, subject to the Deferred Effective Date provision.

## BENEFITS

### **When do benefits become payable?**

You will be paid a monthly benefit if:

1. You become Disabled while insured under this plan;
2. You are Disabled throughout the Elimination Period;
3. You remain Disabled beyond the Elimination Period;
4. You are, and have been during the Elimination Period, under the Regular Care of a Physician; and
5. You submit proof of loss.

Benefits accrue as of the first day after the Elimination Period and are paid monthly.

**Loss of License:** Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation alone, does not mean that You are Disabled. However, information relating to Your loss of license supporting Your claim for benefits may be submitted as part of Your proof of Loss.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**When will benefit payments terminate?**

We will terminate benefit payment on the first to occur of:

1. the date You are no longer Disabled as defined;
2. the date You fail to furnish Proof of Loss, when requested by us;
3. the date You are no longer under the Regular Care of a Physician, or refuse our request that You submit to an examination by a Physician;
4. the date You die;
5. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
6. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
7. the date You refuse to cooperate with or try:
  - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation, provided a qualified Physician agrees that such modifications or adaptive equipment accommodate Your medical limitation; or
8. the date You refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

**MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS**

**Are benefits limited for Mental Illness or Substance Abuse?**

If You are Disabled because of:

1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable:

1. only for so long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when You are not so confined, a total of 24 months for all such Disabilities during Your lifetime.

**RECURRENT DISABILITY**

**What happens if You return to work but become Disabled again?**

Attempts to return to work as an Active Full-time Employee during the Elimination Period will not interrupt the Elimination Period, provided no more than [30] such return-days are taken.

Any day You were Actively at Work will not count towards the Elimination Period.

After the Elimination Period, when a return to work as an Active Full-time Employee is followed by a recurrent Disability, and such Disability is:

1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work,

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided the Group Insurance Policy remains in force.

If You return to work as an Active Full-time Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. A new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits. The Elimination Period and Maximum Duration of Benefits Table are in the Schedule of Insurance. The term "Period of Disability" as used in this provision means a continuous length of time during which You are Disabled under this plan.

## **CALCULATION OF MONTHLY BENEFIT**

### **How are benefits calculated for Disability?**

If You are Disabled after the Elimination Period, Your Monthly Benefits will be calculated as follows:

1. multiply Your Pre-disability Earnings by the Benefit Percentage shown in the Schedule of Insurance;
2. identify the Maximum Benefit shown in the Schedule of Insurance; and
3. compare the amounts determined in items (1) and (2) above, and from the lesser amount subtract:
  - a) all Other Income Benefits; and
  - b) Current Monthly Earnings.

The result is Your Monthly Benefit. [Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.]

If a reduction to Your Monthly Benefit is applied for Current Monthly Earnings, we will adjust your Pre-disability Earnings for inflation annually by the percentage change in the Consumer Price Index (CPI-W) prior to taking that reduction. The adjustment will be made January 1st each year after you have been Disabled for 12 consecutive months, and if you are receiving benefits at the time the adjustment is made.

For the first 12 months that benefits are payable while working, We will only reduce Your Monthly Benefit by that amount of Your Current Monthly Earnings, which when combined with Your Monthly Benefit amount exceed 100% of Your Indexed Pre-disability Earnings. After 12 months We will subtract 50% of Your Current Monthly Earnings.

## **RETURN TO WORK INCENTIVE**

### **How are benefits calculated if You return to limited duties during or following the Elimination Period?**

For the first 12 months of a period of Partial Disability, Your Monthly Benefit will be calculated as follows:

- 1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
- 2) Compare the result with the Maximum Benefit; and
- 3) From the lesser amount, deduct Other Income Benefits.

This is Your Monthly Benefit.

Your Monthly Benefit will be reduced by the amount of Your Current Monthly Earnings, which when combined with Your Monthly Benefit amount exceed 100% of Your Indexed Pre-disability Earnings.

### **How are benefits calculated after the 12th Monthly Benefit has been paid?**

After 12 months of benefit have been paid to You for Partial Disability and for any remaining or additional periods of Partial Disability, Your Monthly Benefit will be calculated as follows:

- 1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
- 2) Compare the result with the Maximum Benefit; and
- 3) From the lesser amount, deduct Other Income Benefits and 50% of Your Current Monthly Earnings.

The result is Your Monthly Benefit.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

[Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.]

Benefit Percentages and Maximum Benefits are shown in the Schedule of Insurance.

### **VOCATIONAL REHABILITATION/ REHABILITATIVE EMPLOYMENT**

#### **What Vocational Rehabilitative services are available?**

**Vocational Rehabilitation** means employment or services that prepare You, if Disabled, to resume gainful work. If You are Disabled, our Vocational Rehabilitative Services may help prepare You to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. work-place modification, to the extent not otherwise provided;
4. prosthesis; or
5. job placement.

**Rehabilitative Employment** means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by us.

#### **Do earnings from Rehabilitative Employment affect the Monthly Benefit?**

If You are Disabled and are engaged in an approved program of Rehabilitative Employment, For the first 12 months that benefits are payable to You under this provision, the sum of Your Monthly Benefit and Your earnings received from Rehabilitative Employment may not exceed 100 % of Your Indexed Pre-disability Earnings. If it does, the Monthly Benefit will be reduced by the amount of excess. We will deduct any Other Income Benefits from the Monthly Benefit payable to You under this provision.

After 12 months of benefits have been paid under this provision, Your Monthly Benefit will be:

1. the Monthly Benefit amount calculated payable for Disability; but
2. reduced by Other Income Benefits and 50% of the income received from each month of such Rehabilitative Employment

### **FAMILY CARE CREDIT BENEFIT**

#### **What if You must incur expenses for Family Care Services in order to participate in a Rehabilitative program?**

If You are working as part of a program of Rehabilitative Employment, we will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from a Rehabilitative program, subject to the following limitations:

1. Family Care means the care or supervision of:
  - a) Your children under age 13; or
  - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2. the maximum monthly deduction allowed for each qualifying child or family member is:
  - a) \$350 during the first 12 months of Rehabilitative Employment; and
  - b) \$175 thereafter,
  - c) but in no event may the deduction exceed the amount of Your monthly earnings;

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

3. Family Care Credits may not exceed a total of \$2,500 during a calendar year;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
  - a) You are no longer in a Rehabilitative program; or
  - b) Family Care Credits for 24 months have been deducted during Your Disability; and
7. no Family Care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under the plan if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

### **SURVIVOR INCOME BENEFIT**

**Will Your survivors receive a benefit if You should die while receiving Disability Benefits?**

If You die while receiving benefits under this plan, a Survivor Benefit will be payable to:

1. Your surviving Spouse;
2. Your surviving Child(ren), in equal shares, if there is no surviving Spouse; or
3. Your estate, if there is no surviving Spouse or Child.

If a minor Child is entitled to benefits, we may, at our option, make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The Benefit is one payment of an amount that is [3] times the lesser of:

1. Your Monthly Income Loss multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.

The following terms apply to this Benefit:

"Spouse" means Your wife or husband who:

- a) is mentally competent; and
- b) was not legally separated from You at the time of Your death.

Surviving Child(ren) includes children of Your California registered domestic partner.

With respect to California residents only, "Spouse" will include an individual who is in a registered domestic partnership with the employee in accordance with California law. Reference in this form to an employee's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

### **WORKPLACE MODIFICATION BENEFIT**

**Will our Rehabilitation program provide for modifications to the workplace to accommodate a Disabled employee's return to work?**

We will reimburse Your Employer for the expense of reasonable modifications to Your workplace to accommodate Your Disability and enable You to return to work as an Active Full-time Employee. To qualify for this benefit:

1. Your Disability must be covered by this plan;
2. the Employer must agree to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the essential duties of Your job; and
3. any proposed modifications must be approved in writing by us.

Benefits paid for such workplace modification shall not exceed the amount equal to Your Pre-disability Earnings multiplied by the Benefit Percentage.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

We have the right, at our expense, to have You examined or evaluated by:

1. a physician or other health care professional; or
2. a vocational expert or rehabilitation specialist,

of our choice so that we may evaluate the appropriateness of any proposed modification.

The Employer's costs for approved modifications will be reimbursed after:

1. the proposed modifications made on Your behalf are complete;
2. we have been provided written proof of the expenses incurred to provide such modification; and
3. You have returned to work as an Active Full-time Employee.

This Workplace Modification benefit will not be payable if:

1. the Employer does not incur any cost in making the modification;
2. we have not given written approval of the modification prior to expenses being incurred; or
3. You become self-employed, or return to work for another employer.

**Workplace Modification** means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this plan.

### **PRE-EXISTING CONDITIONS LIMITATIONS**

#### **Are there any other limitations on coverage?**

We will not pay a Benefit for any loss or any period of Disability beginning within the first [ 12 ] months of the effective date of Your coverage under this policy if the period of Disability is caused by or substantially contributed to by a Pre-existing condition or the medical or surgical treatment of a Pre-existing condition.

You have a Pre-existing condition if:

- 1) You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the [3] months immediately prior to the effective date of coverage under The Policy; or
- 2) You suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in Your application and;
  - a) for which You received a physician's advice or treatment within [3] months before the date of Your coverage under The Policy; or
  - b) which caused symptoms within [3] months before the date of issue for which a prudent person would usually seek medical advice or treatment.

### **CONTINUITY FROM A PRIOR PLAN**

#### **Is there continuity of coverage from a Prior Plan?**

If you were:

1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

---

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

If you become insured under the Group Insurance Policy on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:

1. the Plan Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the previous paragraph will be the lesser of:

1. the Monthly Benefit which was paid by the Prior Plan; or
2. the Monthly Benefit provided by this plan.

No payment shall be made after the earlier to occur of:

1. the date payments would have ceased under the Prior Plan; or
2. the date payments cease under this plan.

If you received Monthly Benefits for Disability under the Prior Plan, and:

1. you returned to work as an Active Full-time Employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

## **EXCLUSIONS**

### **What Disabilities are not covered?**

The plan does not cover, and no benefit shall be paid for any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war (declared or not);
3. caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation;
4. caused or contributed to by an intentionally self-inflicted injury.

## **TERMINATION**

### **When does your coverage terminate?**

You will cease to be covered on the earliest to occur of the following dates:

1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution;
5. the date you cease to be an Active Full-time Employee in an eligible class including:
  - a) temporary layoff;
  - b) leave of absence; or
  - c) a general work stoppage (including a strike or lockout); or
6. the date your Employer ceases to be a Participant Employer, if applicable.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**Does your coverage continue if your employment terminates because you are Disabled?**

If you are Disabled and you cease to be an Active Full-time Employee, your insurance will be continued:

1. during the Elimination Period while you remain Disabled by the same Disability; and
2. after the Elimination Period for as long as you are entitled to benefits under the Policy.

**Must premiums be paid during a Disability?**

No premium will be due for you:

1. after the Elimination Period; and
2. for as long as benefits are payable.

**Do benefits continue if the plan terminates?**

If you are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:

1. will continue as long as you remain Disabled by the same Disability; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no effect on our liability under this provision.

**May coverage be continued during a family or medical leave?**

If you are granted a leave of absence according to the Family and Medical Leave Act of 1993, your Employer may continue your insurance for up to 12 weeks, or longer if required by state law, following the date your coverage would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for you must be paid;
3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
  - a) the leave terminates prior to the agreed upon date;
  - b) the termination of the Group Insurance Policy;
  - c) non-payment of premium when due by the Policyholder or you;
  - d) the Group Insurance Policy no longer insures your class; oryour Employer ceases to be a Participant Employer, if applicable.

**GENERAL PROVISIONS**

**Time Limits on Certain Defenses: What happens if facts are misstated?**

After three years from the date of issue of this Policy, no misstatement of the employer, except a fraudulent misstatement made in the application shall be used to void the Policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after expiration of such three years.

**Notice of Claim: When should We be notified of a claim?**

You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as reasonably possible. Such notice must include your name, your address and the Group Insurance Policy number. Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at our offices in Hartford, Connecticut, or to any of our authorized agents, with information sufficient to identify the insured, shall be deemed notice to the insurer.

**Claim Forms: Are special forms required to file a claim?**

We will, upon receipt of written claim notice, furnish to You such forms as are usually furnished by us for filing proof of loss. If such forms are not furnished within 15 days after We receive written notice of claim You shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

When we receive a notice of claim, you will be sent forms for providing us with proof of loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

**Proof of Loss: When must proof of Disability be given?**

Written proof of loss must be furnished to the insurer at our offices in Hartford, Connecticut in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**Physical Examinations and Autopsy: What additional proof of Disability are We entitled to?**

At our Own expense, We shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

**Time Payment of Claims: When are payment checks issued?**

Indemnities payable under the policy for any loss other than loss for which the policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the policy provides periodic payment will be paid on a monthly basis and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: We may have you examined to determine if you are Disabled. Any such examination will be:

1. at our expense; and
2. as reasonably required by us.

**Who gets the benefit payments?**

All payments are payable to you. Any payments owed at your death may be paid to your estate. If any payment is owed to your estate, we may pay up to \$1,000 to any of your relatives who is entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid. All payments are payable to You. Any payments owed at Your death may be paid to Your estate [or Your beneficiary]. If any indemnity of the policy shall be payable to Your estate or to a person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1000.00 to any relative by blood or connection by marriage of such person or beneficiary whom We deem to be equitably entitled thereto. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

**What notification will You receive if Your claim is denied?**

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:

1. give the specific reason(s) for the denial;
2. make specific reference to the Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

**What recourse do You have if Your claim is denied?**

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
  - b) 60 days of receipt of claim denial for all other claims; and

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

**Legal Action: When can legal action be started?**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**How will We Determine Your Eligibility for Benefits?**

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits for any claim You [or Your beneficiaries] make on The Policy. We will:

- 1) obtain, with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
- 2) consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination Your eligibility for benefits based on that information and in accordance with the Policy and applicable law;
- 3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
- 4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with the Policy as described in the provision entitled "What notification will You receive if Your claim is denied?"

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled "What recourse do You have if Your claim is denied?" If You do not appeal the decision to Us, then the decision will be Hartford's final decision.

**DEFINITIONS**

The terms listed will have these meanings.

**Actively at Work**

You will be considered to be actively at work with your Employer on a day which is one of your Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time basis on that day. You will be deemed to be actively at work on a day which is not one of your Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

**Active Full-time Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours indicated in the Schedule of Insurance.

**Any Occupation**, if used in this Booklet-certificate, means an occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**Bonuses** mean the monthly average of bonuses paid to you by the Employer over the [1]calendar year(s) ending just prior to the date you become Disabled, or over the number of calendar months of employment if less than this period.

**Commissions** mean the monthly average of commissions paid to You by the Employer over the [1] calendar year(s) ending just prior to the date you become Disabled, or over the number of calendar months of employment if less than this period less than this period.

**Current Monthly Earnings** means the monthly earnings You receive from work You perform for Your Employer or for another employer with whom You became employed after Your Disability commenced.

**Employer** means the Policyholder.

**Essential Duty** means the substantial and material acts that are normally required for the performance of Your Usual Occupation, which cannot reasonably be omitted or modified.

To be at work for the number of hours in Your regularly scheduled workweek is also an Essential Duty. [ However, to be at work in excess of [40] hours a week is not an Essential Duty.]

**Indexed Pre-disability Earnings** when used in this policy means your Pre-disability Earnings adjusted annually by the percentage change in the Consumer Price Index (CPI-W).

The adjustment is made January 1st each year after you have been Disabled for 12 consecutive months, and if you are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, we may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31st, and the prior year's CPI-W as of July 31st, divided by the prior year's CPI-W.

**Mental Illness** means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral or emotional disorders, but excluding demonstrable, structural brain damage.

**Monthly Benefit** means a monthly sum payable to you while you are Disabled, subject to the terms of the Group Insurance Policy.

**[Monthly Rate of Basic Earnings** means your regular monthly rate of pay, [including/not including] [ Bonuses], [shift differential pay] and [Commissions] from the Employer just prior to the date you become Disabled:

1. including contributions you make through a salary reduction agreement with the Employer to:
  - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
  - b) an executive non qualified deferred compensation arrangement; or
  - c) a salary reduction arrangement under an IRC Section 125 plan; and
2. [not including overtime pay, stock options, earnings as an independent contractor or expense reimbursements for the same period as above. ]

**Other Income Benefits** mean the amount of any benefit for loss of income, provided to You as a result of the Disability for which You are claiming benefits under this plan. This includes any such benefits that are paid to You or to a third party on Your behalf. This includes the amount of any benefit for loss of income from: the United States Social Security Act, Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that You are eligible to receive because of Your Disability;

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

1. the Veteran's Administration or any other governmental agency for the same Disability;
2. any governmental law or program that provides disability benefits as a result of Your job with the Employer;
3. [[salary continuation],[ sick pay ]or [paid time off]];
4. the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;
5. any temporary disability benefits under a workers' compensation law, occupational disease law, or similar law.

[Other Income Benefits also means the amount of any benefit for loss of income, provided to Your family from the United States Social Security Act, The Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that Your family is eligible to receive as a result of the Disability for which You are claiming benefits under this plan. ]

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

Any general increase in benefits required by law that You are entitled to receive under any Federal Law will not reduce the Long Term Disability Benefit payable for a period of Disability that began prior to the date of such increase.

If You are paid Other Income Benefits in a lump sum, We will pro-rate the lump sum:

1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined over a period of 24 months.

We may require:

1. Your signed statement identifying all Other Income Benefits; and
2. proof that You [and Your family] have duly applied for all Other Income Benefits We reasonably believe You [or Your family] are entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

You will be required to apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You will be required to apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

- 1) to follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals if such action can reasonably be expected to result in an award.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence.

If Your disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

We will use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You [or Your family] are entitled or eligible to receive them but You [or Your family] have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You [or Your family] have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Monthly Benefit payable under this plan even if You [or Your family] are not receiving these benefits.

We will use any reasonable means to estimate the amount of temporary disability benefits payable to You under a workers compensation law or any other occupational disease law or similar act; or the amount of benefits payable to You under any statutory benefit law, plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of these benefits from Your Monthly Benefit payable under this plan even if You are not receiving these benefits.

**Partial Disability or Partially Disabled** means You are not Totally Disabled, and while actually working in an occupation, as a result of sickness or injury, You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience or station in life, and physical and mental capacity.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other healing art recognized by us;
2. licensed to practice in the state or jurisdiction where care is being given; and
3. practicing within the scope of that license.

**Pre-disability Earnings** means your Monthly Rate of Basic Earnings in effect on the day before you became Disabled.

**Prior Plan** means the long term disability insurance carried by the Employer on the day before the Plan Effective Date.

**Regular Care of a Physician** means you are attended by a Physician, who is not related to you:

1. with medical training and clinical experience suitable to treat your disabling condition; and
2. whose treatment is:
  - a) consistent with the diagnosis of the disabling condition;
  - b) according to guidelines established by medical, research and rehabilitative organizations; and
  - c) administered as often as needed,

to achieve the maximum medical improvement.

**Retirement Plan** means a defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions. It does not include:

1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan or 403(b) plan.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

**Substance Abuse** means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

**Total Disability or Totally Disabled:** means during the Elimination Period and for the next [24 ]months, as a result of injury or sickness, You are unable to perform with reasonable continuity the Essential Duties necessary to pursue Your occupation in the usual or customary way.

After that, as a result of injury or sickness you must be so prevented from performing the Essential Duties of Any Occupation.

**We, us or our** means the Hartford Life and Accident Insurance Company.

**You, your, Insured Person** means the Insured Person to whom this Booklet-certificate is issued.

**Your Occupation or Your Usual Occupation,** if used in this Booklet-certificate, means any employment, business, trade or profession and the substantial and material acts of the occupation You were regularly performing for Your Employer when the disability began. Your Occupation is not necessarily limited to the specific job You performed for Your Employer.

---

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

## ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT BENEFIT (Optional Benefit)

### What benefits are payable for dismemberment or loss of sight due to an accidental bodily injury?

If you suffer an accidental bodily injury while insured and a loss listed in the Schedule below results directly from such injury within [365 ]days after the date of the accident causing the injury, the Monthly Benefit for Disability will be payable for at least the number of months shown in the Schedule. The benefit amount is the lesser of:

1. the Maximum Monthly Benefit shown in the Schedule of Insurance ; or
2. your Pre-disability Earnings multiplied by the Benefit Percentage .

### SCHEDULE

<b>For Loss of:</b>	<b>Minimum Number of Monthly Benefit Payment</b>
Both Eyes	<b>46</b>
Both Hands or Both Feet	<b>46</b>
One Hand and One Foot	<b>46</b>
One Hand and One Eye	<b>46</b>
One Foot and One Eye	<b>46</b>
One Hand or One Foot	<b>23</b>
One Eye	<b>15</b>
Thumb and Index Finger of Either Hand	<b>12</b>

Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint. Loss of an eye means that sight in the eye:

1. is completely lost; and
2. cannot be recovered or restored.

Loss of a thumb or index finger means an actual severance through or above the metacarpophalangeal joint.

If you incur more than one of the listed losses as the result of the same accident, the number of monthly benefit payments that you will receive will be limited to the loss for which the greatest number of monthly benefit payments are provided in the Schedule.

Benefits may continue to be payable to you after the Minimum Number of Monthly Benefit Payments have been made if you are then Disabled. If you die after the Elimination Period, but before the minimum number of monthly benefit payments have been made, the remaining monthly benefit payments will be made to your estate.

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

## **COST-OF-LIVING ADJUSTMENT (Optional Benefit)**

If you are Disabled and your Current Monthly Earnings are less than 20% of your Pre-disability Earnings, your Monthly Benefit for Disability may increase in accordance with the Cost-of-Living formula described below. The Cost-of-Living Adjustment is made each year on January 1st. Your Monthly Benefit may increase under this formula provided you:

- 1) have been so Disabled for 12 consecutive months;
- 2) remain so Disabled; and
- 3) are receiving a Monthly Benefit when the Cost-of-Living Adjustment is made.

### **What is the Cost-of-Living Formula?**

We will increase your Monthly Benefit by the lesser of:

- 1) [3%/6%]; or
- 2) 1/2 the percentage change in the Consumer Price Index.

### **How long will Cost-of-Living Adjustments continue?**

No Cost-of-Living Adjustment will be made after your Current Monthly Earnings are 20% or more of your Pre-disability Earnings, [or you have received [5-10] adjustments].

**The term Consumer Price Index (CPI-W) means** the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, we may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

## **PENSION CONTRIBUTION BENEFIT (Optional Benefit)**

### **Does this plan also cover contributions to a Pension Plan?**

If you:

1. become Disabled while you are covered under this Pension Contribution Benefit;
2. remain Disabled for 365 days of one continuous period of Disability; and
3. are receiving a Monthly Benefit under this plan,

a Pension Contribution Benefit will be payable to the trustee or administrator of your Pension Plan for deposit to your pension account. The Pension Contribution Benefit amount will be the least of:

1. 15% of your Pre-disability Earnings;
2. \$2,500;
3. the amount of the average monthly tax deferred contributions the Employer made to your Pension Plan during the 12 calendar months prior to becoming Disabled.

Payments under this benefit are made according to the rules and regulations of the Internal Revenue Service and the provisions of your Pension Plan. Any such payment that can not be paid to the trustee or administrator of your Pension Plan will be paid to a deferred annuity account designated by you.

### **How long will payments be made under this benefit?**

No Pension Contribution Benefit will be payable after your Monthly Benefit for Disability ends for any reason.

**Pension Plan** means, for the purpose of this Pension Contribution Benefit, a qualified defined contribution pension plan, profit sharing plan, or other plan approved by us, in which you are participating as a result of your employment with the Employer.

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.

## CONVERSION PRIVILEGE (Optional Benefit)

### Under what conditions can your Long Term Disability Coverage be converted to another plan?

If your insurance terminates because:

1. your employment ends for reason other than your retirement; or
2. you are no longer in an eligible class,

and if:

1. you have been continuously insured for at least 12 consecutive months under this plan or under this plan and the Prior Plan;
2. you are under the Limiting Age, if any is shown in the Schedule of Insurance;
3. a Disability is not preventing you from performing duties of Your Occupation;
4. the insurance for your class, or the plan has not terminated;
5. you are not eligible for coverage under the plan under another class; and
6. you are not eligible or covered for similar benefits under another group plan or an individual policy,

then you are eligible to enroll for personal insurance under another group policy called the Group Long Term Disability Conversion Policy.

Prior Plan, as used in this Conversion Privilege provision, means the plan of group long term disability insurance that was provided or sponsored by the Employer and terminated on the day before the Plan Effective Date.

### How to convert

To obtain coverage under the Group Long Term Disability Conversion Policy, the following must be done within 31 days of the termination of group insurance:

1. a written enrollment request must be made to us; and
2. the required premium and enrollment fee for the conversion policy must be paid.

If the preceding conditions are met, we will issue to you a certificate of insurance under the Group Long Term Disability Conversion Policy. Such coverage will:

1. be issued without medical evidence of insurability;
2. be on one of the forms then being issued by us for conversion purposes; and
3. be effective on the day following the date your insurance under this plan terminates.

The coverage available under the conversion policy may differ from this plan. The terms of the Group Long Term Disability Conversion Policy, including:

1. the type and amount of coverage provided; and
2. the premium payable,

will be determined by the kinds of insurance being provided by the Group Long Term Disability Conversion Policy at the time such enrollment request is made.

**Note:** This is a sample contract and does not constitute a legal document. Language shows common customer choices, not all available options.

The provisions herein are not intended to be relied upon as the benefits you purchase.