Chubb Logo/Combined Logo

Combined Insurance Company of America
A Legal Reserve Stock Corporation

Home Office: 111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601
1-800-544-9382
Policyholder Service Address: P. O. Box 1160 • Glenview, Illinois 60025-8160

GROUP DISABILITY INCOME INSURANCE POLICY
Non-participating
Policy Specifications

POLICYHOLDER:	MEMORIAL HEALTHCARE SYSTEM	
POLICY EFFECTIVE DATE:	January 01, 2023	
POLICY ANNIVERSARY DATE:	January 01, 2024	and each following January 01
PREMIUM DUE DATE:	January 01, 2023	and the First of each month thereafter
RATE GUARANTEE DATE:	January 01, 2024	
GOVERNING JURISDICTION:	Florida	
ELIGIBLE CLASS(ES):	ALL ELIGIBLE EES	
	ALL ELIGIBLE DEPS	

COMBINED INSURANCE COMPANY OF AMERICA (referred to as We, Us, Our, or the Company) will provide benefits under this Policy. We make this promise subject to all of this Policy's provisions.

The Policyholder should read this Policy carefully and contact Us promptly with any questions. This Policy is delivered in and is governed by the laws of the Governing Jurisdiction.

This Policy may be changed in whole or in part. Only an officer of the Company can approve a change. The approval must be in writing and endorsed on or attached to this Policy. No other person, including an agent, may change this Policy or waive any part of it.

Signed for the Company at its home office in Glenview, Illinois.

Kevin Goulding, President

Rebecca L. Collins, Secretary

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POLICYHOLDER PROVISIONS

CLERICAL ERROR
Clerical error on the part of the Policyholder or Us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the Policyholder documenting any clerical errors.

EFFECTIVE DATE OF COVERAGE
The Policy becomes effective on the Policy Effective Date shown in the Policy Specifications. Coverage for each Insured begins on the Effective Date as defined in the Certificate.

ENROLLMENT
An individual who is a member of an Eligible Class may enroll for coverage during the eligibility period established by the Policyholder for that Eligible Class, that follows the later of:

1) The Policy Effective Date shown in the Policy Specifications; or
2) The date the individual first becomes a member of an Eligible Class.

ENTIRE CONTRACT
The Entire Contract consists of:
1. This Policy;
2. The Policyholder's application;
3. Any amendments and attachments issued;
4. The Certificate(s) and any Rider(s); and
5. Any enrollment data and the evidence of insurability form provided by the Insureds.

INFORMATION REQUIRED FROM THE POLICYHOLDER
The Policyholder must provide Us with detailed information about persons who are eligible to become insured under the Policy, information about Insureds, and any other information that may be reasonably required.

Policyholder records that have a bearing, in Our opinion, on the Policy will be available for review by Us at any reasonable time as determined by Us.

LEGAL ACTION
No legal action can be brought to recover benefits under the Policy for at least sixty (60) days after written proof of Loss has been furnished to Us; nor after the expiration of three (3) years after the date proof of Loss is required.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Policy Effective Date, no misstatements, except fraudulent misstatements, of the Policyholder can be used to void the Policy. After two (2) years from the Certificate Effective Date of an Individual Certificate, no misstatements, except fraudulent misstatements, of the Insured can be used to void coverage or deny a claim for Loss incurred or Disability commencing after the expiration of the two (2) year period.

INCONTESTABILITY
We may not contest the validity of this Policy after the Policy has been in effect for two (2) years, unless the premium has not been paid or due to fraudulent misrepresentations.

We will not use such statements to reduce or deny a claim or cancel insurance, unless it is in a written application which has been made a part of the Policy. We will not use such statements to contest the disability income insurance under the Policy after it has been in effect for two (2) years from its Effective Date, or date of last reinstatement if applicable, except in the case of fraud, where permitted by applicable law of the Governing Jurisdiction. For any applied for increases in coverage, a new two (2) year contestability period is applicable to the amount of the applied for increase.

No statement will be used to contest the insurance under the policy unless the statement is material to the risk accepted by us.

POLICY RENEWAL
The Policy shall automatically renew on each anniversary of the Policy Anniversary Date, subject to the Termination of Policy provision.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state where the Policyholder is located is amended to conform to the minimum requirements of such laws.

PREMIUM

PAYMENT OF PREMIUM
The Policy is issued in consideration of the Policy application and payment of the first premium. The first premium is based on the initial rate(s) shown in the Rate Table. The first premium is due on the Premium Due Date shown in the Policy Specifications. The Policyholder must send all premiums to us on or before their respective Premium Due Dates. Payments must be paid in United States dollars. We may use any reasonable method to compute premiums due under this Policy.

GRACE PERIOD
After payment of the first premium, if a premium is not paid on or before the Premium Due Date, it may be paid during the next 31 days. These 31 days are called the Grace Period. Coverage will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, coverage shall automatically terminate and this Policy will no longer be in force. This Grace Period does not apply if the Policyholder requested the Policy be terminated.

If the full premium is not paid by the due date, We will provide written notice to You that if the premium is not paid by the end of the Grace Period, the Policy will terminate on the last day of the Grace Period. If We fail to give written notice, the insurance provided under the Policy will continue in effect until the date such notice is given.

If You replace the Policy with another group policy but do not give Us written notice of intent to end the Policy, the Grace Period provision of the Policy will still apply.

You are required to pay a pro rata premium for any period the Policy was in force during the Grace Period.

Premium is required for any period, including the Grace Period or any extension of the Grace Period, for which insurance under the Policy was in force and premium was not paid.

INITIAL RATE GUARANTEE AND CHANGES IN PREMIUM
We have the right to adjust the premium for the Policy once each calendar year. A change in premium will not take effect before the Rate Guarantee Date shown in the Policy Specifications. However, We may change premium rates at any time for reasons which materially affect the risk assumed, including but not limited to:

1) A change occurs in the Policy design;
2) The number of Insureds changes by 10%;
3) A new law or a change in an existing law affecting premium taxes or premium-based fees or other fees or assessments affecting Us;
4) There is a significant change in the geographic distribution of Insureds; or
5) When a Policyholders subsidiary, affiliate, division, branch or other similar entity is added to or deleted from the Policy for any reason, including corporate restructuring, acquisitions, spin-off or similar situations.

A premium adjustment will take effect on the next Policy Anniversary following the adjustment. A change may take effect on an earlier date when both We and the Policyholder agree. Written notice of a premium adjustment will be delivered to the Policyholder and Insureds at least sixty (60) days advance.

The Policyholder shall provide Us with all the data needed to compute premiums and administer the terms of the Policy. We shall have the right to examine the Policyholder insurance data at any time. If Combined or the Policyholder makes a clerical error in keeping the data, the premiums 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.

REINSTATEMENT OF POLICY
If premium is not paid within the period specified and is subsequently accepted by Us without requiring an application for reinstatement, the Policy will be reinstated.

DEFINITIONS

Certificate means the document that defines benefits and provisions, and explains the parts of the Policy which apply to the Insureds.

Eligible Class(es) means the people who may apply for coverage. The Eligible Class(es) are shown in the Policy Specifications.

Insured means the person covered under the Policy according to the terms of the Policy and Certificate.

Loss means an event for which a benefit may become payable under the Policy.

We, Our, Us or the Company means Combined Insurance Company of America.

TERMINATION

The Policy terminates on the date there are no longer any Insureds covered under it.

Coverage under the Policy may also be terminated:

1) By the Policyholder with at least 60 days advance written noticed delivered or mailed to Us; or
2) By Us with at least 60 days advance written notice delivered to the Policyholder.

When both We and the Policyholder agree, the Policy can be canceled on an earlier date.

Coverage under the Policy may be modified by Us with at least 60 days advance written notice delivered to the Policyholder.

CERTIFICATES

The Certificate(s) designated in Appendix A, and any amendments thereto, are attached to and made part of the Policy. Any discrepancy or inconsistency between the attached Certificate(s) and any individual Certificate issued to an Insured is governed by the attached Certificate.

The Certificate(s) apply to Insureds in accordance with the coverages and benefits elected by the Policyholder in its application and accepted by the Company.

INDIVIDUAL CERTIFICATES
An individual certificate of insurance which sets forth (a) a description of the benefits and coverages, and (b) exclusions or limitations that apply to such benefits and coverages shall be available to each Insured.

APPENDIX A

CERTIFICATE TYPE	FORM NUMBER
Group Disability Income Certificate	Form No. C60501-FL

Combined Insurance Company of America

Home Office: 111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601
1-800-544-9382
Policyholder Service Address: P. O. Box 1160 • Glenview, Illinois 60025-8160

GROUP DISABILITY INCOME INSURANCE CERTIFICATE

PLEASE READ YOUR CERTIFICATE CAREFULLY. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS

This is Your Certificate while You are insured. This Certificate is in force as of the Certificate Effective Date. The Certificate Effective date is defined under this Certificate.

This Certificate replaces any previous certificate of insurance issued for the coverage described in this Certificate.

You are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. The Policy issued to the Policyholder includes a copy of this Certificate. The Policy is a contract between Us and the Policyholder. The Policy constitutes the agreement under which payments are made. Benefit payment is governed by all the terms, conditions and limitations of the Policy. We will pay the benefits set forth in this Certificate. If the terms and provisions of the Certificate are different from the Policy, the Policy will govern. You may inspect a copy of the Policy upon request to Your Employer. This Certificate may be delivered in electronic format.

This Certificate was issued on the basis that the information provided by the Policyholder and any information provided by You are correct and complete. If any information is not correct or complete, write to Us within 10 days of receipt of this Certificate. Incorrect or incomplete information can result in the denial of a claim, rescission, or termination of coverage.
The coverage under the Certificate is renewable according to the terms and provisions of the Policy and Certificate.

We reserve the right to change the premium.

We will notify You in writing, at Your last address of record, of a change at least 60 days before the date at which it is to become effective.

PRE-EXISTING CONDITION LIMITATION

A Pre-existing Condition is not covered unless the date of diagnosis for such condition is at least 12 months after the Certificate Effective Date.

For Combined Insurance Company of America

Kevin Goulding, President

Rebecca L. Collins, Secretary

Form No. C60501-FL

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SCHEDULE

CERTIFICATE SPECIFICATIONS

Insured:

Certificate Number: BKRC29326

Certificate Effective Date: 01/01/2023

Premium Amount:

Insured Issue Age:

Premium Mode:

Policyholder: MEMORIAL HEALTHCARE SYSTEM

Governing Jurisdiction: FL

Policyholder's Address: 3501 JOHNSON STREET
HOLLYWOOD FL 33021

Class: ALL ELIGIBLE EES

Telephone Number:

SCHEDULE OF BENEFITS

Active Employee Requirement:	20 hours per week
Maximum Benefit Amount:	$5,000 per month, not to exceed 60% of Your Monthly Earnings
Minimum Benefit amount:	$200
Maximum Benefit Period:	6 Months
Elimination Period:	
Accident:	14 Days
Sickness:	14 Days
Maximum Mental or Nervous Disorder Benefit Amount:	50% Of Maximum Benefit Amount
Maximum Substance Abuse Benefit Amount:	50% Of Maximum Benefit Amount
Partial Disability Benefit Amount:	50% Of Maximum Benefit Amount
Source of Disability:	
Sickness:	100% Of Maximum Benefit Amount
Non occupational injury:	100% Of Maximum Benefit Amount
Waiver of Premium Benefit:	Waives premium when You are Disabled for 30 or more consecutive days, or after the Elimination Period, whichever is greater

Evidence of Insurability may be required for coverage.

Additional Benefits Riders

The following additonal benefits are included:

Infectious and Contagious Disease Benefit Rider

Survivor Benefit Rider

SECTION A

DEFINITIONS

Accident means an unintended and unforeseen injurious event which:

1. Occurs on or after the Certificate Effective Date;
2. Occurs while this Certificate is in force; and
3. Is not excluded by name or specific description in this Certificate.

Active Employee, Actively at Work, Active Employment means You are at work at least the number of hours per week shown on the Schedule of Benefits (see Active Employee Requirement) as a Full Time Employee or Part-time Employee and performing the normal duties of Your Occupation. You are deemed to be Actively at Work on each day of regular paid vacation or legal holiday if:

1. You are not Disabled; and
2. You were Actively at Work on the last working day before such vacation or legal holiday.

Certificate Effective Date means the date coverage under this Certificate becomes effective. The Certificate becomes effective: 1) On the Policy Effective Date if You are in an Eligible Class on or before the Policy Effective Date and Your enrollment was approved by Us; or 2) On the first day of the month following the date Your enrollment was approved by Us if You enter into an Eligible Class after the Policy Effective Date.

Complications of Pregnancy means those conditions, requiring treatment, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, miscarriage, non-elective Cesarean, non-elective abortion and similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and other conditions of comparable severity.

Eligible Employee means a person who is an Active Employee of the Policyholder.

Elimination Period means that period of time during which:

1. You are Disabled; and
2. No disability benefits are payable.

The Elimination Period begins on the first day of Your Disability and is shown on the Schedule of Benefits.

Evidence of Insurability means a statement of Your medical history that will be used to determine if You are approved for coverage.

Full Time Employee means an employee who has a normal workweek of 25 hours or more.

Disabled or Disability means Totally Disabled or Total Disability and Partially Disabled or Partial Disability due to a covered Sickness or Injury.

Disability Benefit is the maximum amount that is payable.

Disability Earnings means the earnings which You receive while You are Disabled and working.

Hospital is an institution in the United States or Canada which meets all of the following requirements:

1. Operates pursuant to state or provincial law for Hospitals located in the United States or Canada;
2. Operates primarily for the care and treatment of sick or injured persons as Inpatients;
3. Provides 24 hour nursing service;
4. Has facilities available for diagnosis and surgery either on its own premises or in facilities available to the Hospital on a pre-arranged basis; and
5. Has a staff of at least one licensed Physician available at all times.

Hospital does not include rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitation facilities, including rehabilitation hospitals.

Immediate Family means:

1. Your partner in a legally sanctioned civil union, domestic partnership, marriage or other family or domestic relations law; or
2. Any person related to You by blood or marriage.

Injury, Injuries means a condition sustained by You which resulted within 90 days from an Accident defined under this Certificate. It does not include sickness, disease or bodily infirmity. Overuse syndromes, typically due to repetitive or recurrent activities, such osteoarthritis, carpal tunnel syndrome or tendonitis, are considered to be a sickness and not an Injury for purposes of this Certificate.

Insured means the person covered under the Policy according to the terms of the Policy and Certificate.

Maximum Benefit Period means the longest period of time for which benefits will be paid for Sickness or Injury. The Maximum Benefit Period is shown on the Schedule of Benefits.

Monthly Earnings means Your gross monthly income from Your employer in effect just prior to the date of disability. Gross monthly income is the total income before taxes and any pre-tax deductions made under a qualified deferred compensation plan recognized by the Internal Revenue Services. It will always be considered to be 1/12th of the basic annual wage payable by Your employer at the start of the term of continuous disability. Regardless of Your timing of payment from Your employer, it will be considered to be received over a 12 month period. It does include commissions and bonuses which will be averaged for the 12 month period just prior to the date of disability. It does not include income received from sources other than Your employer.

If the insured becomes disabled while on a covered Leave of Absence or layoff we will use Your gross monthly income from Your employer in effect just prior to the date the absence began.

Non-Occupational Injury means an Injury that did not occur while working for pay or profit.

Occupational Injury means an Injury that occurs while working for pay or profit.

Part-time Employee means an employee who works less than 25 hours in a normal workweek.

Physician means a person performing tasks that are within the limits of his or her medical license and is:

1. Licensed to practice medicine or psychology and acting within the scope of his or her license to treat an Injury or Sickness causing the Disability; or
2. A legally licensed health care practitioner acting within the scope of his or her license to treat an Injury or Sickness causing the Disability.

A Physician cannot be You or Your Immediate Family, Your business or professional partner, or any person who has a financial affiliation or business interest with You.

Policyholder means the entity to whom the Policy is issued. The Policyholder is shown in the Certificate Specifications.

Recurrent Disability means Your becoming disabled, ceasing to be disabled, then becoming disabled again for the same or related condition within [6] months after the end of a previous disability that is due to the same or related cause.

Regular Care means that You:

1. Personally visit a Physician as frequently as is medically required, according to standard medical practice, to effectively manage and treat Your Disability; and
2. Are receiving appropriate treatment and care of Your Disability, which conforms with standard medical, by a Physician whose specialty or experience is the most appropriate for the disabling condition(s), according to standard medical practice.

Sickness means an illness, infection, disease or any other abnormal physical condition not caused by an Accident that:

1. First makes itself known after the Certificate Effective Date and while this Certificate is in force; and
2. Is not excluded by name or specific description in this Certificate.

Sickness includes organ donation, pregnancy and Complications of Pregnancy.

Totally Disabled or Total Disability means that as a result of a covered Injury or Sickness, for the first 24 months of a disability You are:

1. Unable to perform Your Occupation;
2. Not working at any occupation for pay or benefits; and
3. Under the Regular Care of a Physician for covered Injury or covered Sickness causing such Total Disability.

After 24 months of Total Disability, Totally Disabled means that You are:

1. Unable to perform the material and substantial duties of any occupation for which you are reasonably suited by education, training, and experience;
2. Not working at any occupation for pay or benefits; and
3. Under the Regular Care of a Physician for covered Injury or covered Sickness causing such Total Disability.

We, Our, Us or the Company means Combined Insurance Company of America.

You or Your means an Insured who is covered under the Policy.

Your Occupation means the substantial and material duties required for the regular employment You were performing when Disability began. Your Occupation is not limited to a specific job with a specific employer.

Pre-existing Condition means a condition for which You received medical treatment, advice, consultation, diagnostic testing, care, services or took prescribed drugs or medications within the 6 months preceding the Certificate Effective Date.

SECTION B

BENEFITS

Benefit amounts are shown on the Schedule of Benefits.

TOTAL DISABILITY INCOME BENEFIT
We will pay this benefit after the Elimination Period if we receive sufficient proof that You are Totally Disabled due to a covered Injury or Sickness. Benefits will not continue beyond the Maximum Benefit Period shown on the Schedule of Benefits per Disability.
The benefit amount we will pay when You are Totally Disabled is the Disability Benefit as defined in this Certificate. The benefit payable will never be less than the Minimum Benefit shown on the Schedule of benefits.

WHEN BENEFITS END
Benefits will be paid during a period of Disability until the earliest of the day:

1. You are no longer Disabled.
2. You die.
3. On which the Maximum Benefit Period on the Schedule of Benefits ends.
4. You fail to provide Us satisfactory proof of continuous Disability.
5. You have been incarcerated or imprisoned for 1 day or longer.
6. You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice.
7. You are not under Regular Care for the Sickness or Injury that caused the Disability.
8. You are able to return to work with the Policyholder on a part-time or full-time basis and do not do so.
9) You fail to provide us satisfactory proof of earnings.

RECURRENT DISABILITY BENEFIT
A Recurrent Disability will be treated as a continuation of the previous disability if You were continuously insured under the policy for the period between the prior claim and the Recurrent Disability and the disability is due to the same cause as the original disability. Your Recurrent Disability will be subject to the same terms and conditions as Your prior claim.

CONCURRENT DISABILITIES
If Disability results from more than one Injury and/or Sickness at the same time, or Disability results from two or more causes, it will be considered the same Disability and You will be entitled to disability benefits for only one Disability.

The existence of Concurrent Total Disabilities will not extend the Maximum Benefit Period shown on the Schedule of Benefits or increase the Maximum Benefit Amount.

CREDIT FOR PRE-EXISTING CONDITIONS
If this Certificate replaced another disability income certificate or individual policy, Your coverage under this Certificate shall not limit or exclude coverage for a Pre-existing Condition that would have been covered under the policy being replaced. Time periods applicable to Pre-existing Conditions will be waived to the extent that similar limitations or exclusions were satisfied under the coverage being replaced.

LEAVE OF ABSENCE AND TEMPORARY LAYOFF

If You cease Active Employment with Your current employer due to a Temporary Layoff or Leave of Absence, and if premiums are paid, coverage will be continued for one month following the date Active Employment ceased.

We will continue Your coverage in accordance with Your employer's written human resources policy on Temporary Layoff or Leave of Absence, if premium payments continue and the employer approved Your leave in writing, coverage will continue for one month following the date You ceased Active Employment.

Leave of Absence means You are absent from Active Employment for a period of time that has been agreed to in advance in writing by Your employer. Normal vacation time or any period of disability is not considered a Leave of Absence.

Temporary Layoff means You are absent from active employment for a period of time that has been agreed to in advance by writing by Your employer. Normal vacation time or any period of disability is not considered a temporary layoff.

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PARTIAL DISABILITY INCOME BENEFIT
We will pay this benefit after the Elimination Period if we receive sufficient proof that You are Partially Disabled due to a covered Injury or Sickness.

The Partial Disability Benefit is shown on the Schedule of Benefits.

Partial Disability or Partially Disabled means that as a result of a covered Injury or Sickness You:

1. Are unable to perform some of the material and substantial duties of Your Occupation.
2. Are unable to work at Your job or any other job on more than a part-time basis.
3. Are under the Regular Care of a Physician for covered Injury or Sickness causing such Disability.

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WAIVER OF PREMIUM

We will waive the premium for this coverage and any attached rider(s) after You have been Disabled as the result of a covered Sickness or Injury following the period of time outlined on the Schedule of Benefits.

You must pay all premiums to keep Your coverage and any attached rider(s) in force until You have qualified for waiver of premium as described in this provision. The waiver of premium will not exceed the Maximum Benefit Period shown in the Schedule of Benefits.

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ORGAN DONATION BENEFIT

If Your Disability results from donating an organ in an Organ Transplant procedure, then Your Disability will be covered as a Sickness. The Elimination Period does not apply and disability benefits begin on the first day of resulting disability.

Organ Transplant means the surgical transportation of a kidney, lung, bone marrow, or a portion of the liver, pancreas or intestines into another person.

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SECTION C

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for Disabilities contributed to or caused by:

- Occupational injury;
- Suicide, attempted suicide or intentionally self-inflicted Injury, whether sane or insane.
- Voluntary inhalation of or asphyxiation by gas or fumes.
- Voluntary ingestion or injection of any drug, narcotic, sedative or poison, unless prescribed by and taken in accordance with the directions of the prescribing Physician.
- Being intoxicated or under the influence of alcohol, drugs or any narcotics (including overdose) unless administered on, and taken in accordance with, instructions of a Physician.
- War, declared or undeclared, participating in a riot, insurrection or rebellion.
- Engaging in any illegal or fraudulent occupation, work, or employment.
- Committing or attempting to commit a felony or an assault.
- Travel or flight in or descent from any aircraft other than as a fare-paying passenger on a regularly scheduled airline;

No benefits are payable for Disabilities that occur while you are incarcerated or imprisoned. No benefits are payable for Disabilities that result solely as the result of a loss of a professional license, occupational license, or certificate.

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MENTAL OR NERVOUS DISORDER LIMITATION
The lifetime cumulative Maximum Benefit Period for all Disabilities due to Mental or Nervous Disorder is 24 months. Only 24 months of benefits will be paid even if the Disabilities due to Mental or Nervous Disorder are not continuous and/or are not related.

No benefits will be paid for Disability due to a Mental or Nervous Disorder if You are not receiving treatment for the cause of the Disability from a Physician, or in a facility that is licensed by the state to provide treatment for such condition.

Mental or Nervous Disorder means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to: psychotic, emotional or behavioral disorders, or disorders related to stress or substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability.

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SUBSTANCE ABUSE LIMITATION
The lifetime cumulative Maximum Benefit Period for all Disabilities due to alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid even if the Disabilities are not continuous and/or are not related.

No benefits will be paid for Disability due to a substance abuse if You are not receiving treatment for the cause of the Disability from a Physician, or in a facility that is licensed by the state to provide treatment for such condition.

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SECTION D

ELIGIBILITY, EFFECTIVE DATE, TERMINATION OF COVERAGE, AND PORTABILITY PRIVILEGE.

ELIGIBILITY FOR COVERAGE

To be eligible for coverage under this Certificate:

1. Your enrollment must be approved by Us;
2. You must be age 18 but not more than 74 ; and
3. You are an Eligible Employee in an eligible class on the Certificate Effective Date.

EFFECTIVE DATE

Your coverage will start on the Certificate Effective Date as defined under this Certificate.

TERMINATION OF YOUR INSURANCE

You will cease to be insured under this Certificate on the earliest of the following dates:

1. The end of the period for which premium is paid, subject to the Grace Period provision;
2. The monthly anniversary of the Certificate Effective Date following the date We receive Your written request to have Your insurance terminated;
3. The date You enter into active duty status for the military service of any country;
4. The date on which You are no longer eligible for coverage;
5. Your 72nd birthday;
6. The date of Your death; or
   - The date the policy is canceled, subject to the Portability Privilege provision.

Termination of Your insurance will not affect Your right to benefits, if any, for a Disability that begins while this Certifcate is in force.

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PORTABILITY PRIVILEGE
We will provide disability income insurance portability coverage subject to this provision.

You may continue Your coverage under this Certificate if Your Active Employment with the Policyholder ends subject to the following conditions:

1. On the date Your Active Employment with the Policyholder ends:
   a. You are less than 70 years of age; or
   b. You are not Disabled on the date you apply for portability;
2. We receive a written request and payment of the first premium for the portability coverage no later than 60 days after your active employment with the policyholder ends; and
3. The request is made on a form We furnish or approve for that purpose.

No portability coverage will be provided if Your disability income insurance terminated due to failure to pay premium.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when Your Active Employment with Policyholder ended. Portability coverage will be effective on the date Your Active Employment with Policyholder ended.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which You paid premiums, if You stop making a required premium contribution, subject to the Grace Period.
- The date You reach age 72.
- The date You become covered under another group disability plan.
- The date You die.
- The end of the 12 months during which your coverage is continued under this provision.
- The date the policy terminates and coverage for all Insureds under the Policy terminates, upon 60 days written notice of termination.

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SUSPENSION OF COVERAGE DURING MILITARY SERVICE

If You enter full-time active duty in the United States military or naval services, or the armed forces reserve, including the National Guard, You may request in writing that the coverage be suspended as of the date of active duty status and through the period of such active duty. The suspension of coverage will be allowed up to five (5) years of continuous active duty. Adjustment of premium, if required, will be made when We receive the written notice of Your active duty status. We will refund any unearned premium paid for the period of such suspension. During Your suspension of coverage:

1. The coverage under this Certificate will not be in force; and
2. No premium will be required to be paid.

At the end of Your active duty or at the end of a continuous period of active duty of up to five (5) years, You may reinstate Your coverage without proof of insurability if:

1. You submit a written request to Us; and
2. Such request and the required premium payment is received by Us within 60 days after the date Your active duty ends.

Coverage will be retroactive to the date of termination of active duty.

This Certificate will not cover any loss that results from an injury that occurs during the time of active duty, and which the Secretary of Veteran's Affairs has determined is a condition incurred in the line of duty. All other Certificate terms and conditions will apply to the reinstated coverage.

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SECTION E

CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be given to Us at Our address shown on the first page of this Certificate or as otherwise designated in writing by Us within 30 days after Loss covered by this Certificate occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received by Us. The notice should include Your name, address, telephone number,

CLAIM FORMS
When We receive the notice of claim, We will send the claimant forms for filing Proof of Loss. If these forms are not sent to the claimant within 15 days of our receipt of the notice of claim, the claimant will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the Loss within the time limit stated in the Proof of Loss provision below.

PROOF OF LOSS
Proof of Loss means the written claim form and other information requested by Us substantiating the nature and extent of the Loss. Proof of Loss must be completed and returned to Us within 120 days after the covered loss begins, or as soon as reasonably possible. Verification of continued Disability, when requested, must be provided within 90 days after the end of each monthly benefit period in which the Insured is Totally Disabled or as soon as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date Proof of Loss is otherwise required. You must give us the information We need to determine the reasonableness of any delay, if a benefit is payable, and how much the benefit should be.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this Certificate will be paid immediately upon Our receipt of written Proof of Loss that is satisfactory to Us.

PAYMENT OF CLAIMS
After We receive written Proof of Loss and process Your claim, We will pay any benefits due. Any accrued benefits unpaid at the Insured's death will also be paid to the Beneficiary. If You did not name a Beneficiary, or if no Beneficiary survives the Insured, any benefits due will be paid to the Insured's estate. If benefits are payable to an estate or to a person who cannot give a valid release, We may in our discretion pay up to $3,000 to someone related to the Insured or Beneficiary by blood or marriage. We will be discharged from all liability for any such payment made in good faith.

UNPAID PREMIUM
On payment of a claim under this Certificate, any premium then due and unpaid will be deducted from Your claim payment.

REFUND OF PREMIUM AT DEATH
Upon notice of the Insured's death, We will refund to the Beneficiary the portion of any premium that applies to a period beyond the end of the Certificate month in which death occurred.

RECOVERY OF CLAIM OVERPAYMENT
We reserve the right to recover any payment made by Us that were:

1. Made in error;
2. Made to You and/or any party on Your behalf, where we determine that such payment made is greater than the amount payable under this Policy;
3. Made to You and/or any party on Your behalf based on fraudulent or misrepresented information; or
4. Made to You and/or any party on Your behalf for charges that were discounted, waived, rebated or covered by another major medical carrier or Other Benefits.

If benefits are overpaid or paid in error, We have the right to recover the amount overpaid, or paid in error, including but not limited to, by any of the following methods:

1. A request for You and/or the Covered Person to make a lump sum payment of the amount overpaid or paid in error; and/or,
2. A reduction of any proceeds payable under this Policy for a then-current or future claim(s) by any amounts overpaid or paid in error.

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SECTION F

GENERAL PROVISIONS

ENTIRE CONTRACT
This Certificate is a legal contract between You and Us. The entire contract consists of the Policy, the Policyholder's application, the Certificate, Evidence of Insurability and any endorsements, riders or amendments. No change in this Certificate will be effective until approved by the President, a Vice President, or the Secretary of our Company. This approval must be noted on or attached to this Certificate. No agent or broker has the authority to change this Certificate or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES
Any statements made by You shall be considered a representation and not a warranty. After two (2) years from the Certificate Effective Date, We cannot use misstatements, except fraudulent misstatements, in Your Evidence of Insurability form to void coverage or deny a claim for loss incurred or Disability commencing after the expiration of the two (2) year period. In the absence of fraud, all statements made by the Policyholder, the Employer or You or Your Spouse under the Certificate will be deemed respesentations and not warranties. No statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless it is in writing and a copy of it is furnished to such Policyholder, Employer, You or Your Spouse, or Your representative.

LEGAL ACTIONS
You cannot bring a legal action to recover benefits under Your Certificate for at least 60 days after You have given Us written Proof of Loss as required under this Certificate. No such action may be brought after the expiration of the applicable statute of limitations from the time written Proof of Loss is required to be given.

PAYMENT OF PREMIUM
This Certificate is issued in consideration of the Evidence of Insurability form, enrollment data, information provided by the Policyholder and payment of the first premium. The first premium is due on the Certificate Effective Date. Subsequent premiums are due and payable in advance. If you do not pay the premiums when due, this Certificate will terminate subject to the Grace Period.

All premiums are payable to Us or as otherwise designated in writing by Us. Premiums are payable while coverage continues. Premiums may be paid annually, semi-annually, quarterly, monthly or, subject to Company rules. You may change the frequency of premium payments by filing a written request in a form satisfactory to the Company.

GRACE PERIOD
After You pay the first premium, if a premium is not paid on or before the date it is due, it may be paid during the next 31 days. These 31 days are called the Grace Period. Coverage shall remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, coverage shall automatically terminate and this Certificate will no longer be in force. This Grace Period does not apply if You request termination of this Certificate.

If the full premium is not paid by the due date, We will provide written notice to You that if the premium is not paid by the end of the Grace Period, Your coverage will terminate on the last day of the Grace Period. If We fail to give written notice, the coverage provided under the Policy will continue in effect until the date such notice is given.

You are required to pay a pro rata premium for any period Your coverage was in force during the Grace Period.

Premium is required for any period, including the Grace Period or any extension of the Grace Period, for which insurance under the Policy was in force and premium was not paid.

FRAUD
Fraud is when any person(s) willingly and knowingly engage(s) in an activity intended to defraud Us, by submitting a claim form, application or other form that contain(s) a false or deceptive statement, or other false information.

If You commit fraud, you may also be guilty of the crime of insurance fraud and subject to fine(s) and/or imprisonment or both, if convicted.

If You commit fraud against Us, Your coverage ends automatically, as of the date fraud is committed or as of the date otherwise determined by Us. We will send written notice of cancellation to You at least 5 days prior to the Termination of Your Policy.

We may notify all state and federal law enforcement agencies of any suspected fraud.

We reserve the right to recover any payments made by Us that were made to You and/or any party on your behalf, based on fraudulent or misrepresented information.

REINSTATEMENT
If coverage ends for failure to pay premium, You may apply for reinstatement by submitting an enrollment form and the required premium. Such enrollment form must be submitted within 90 days from the date coverage ended. If We approve the enrollment form, this Certificate will be reinstated on the date of approval of such enrollment form. If We do not notify You that We have approved or disapproved the reinstatement enrollment form, this Certificate will be reinstated on the 45th day after We receive Your completed reinstatement enrollment form and the required premium has been paid to Us.

The reinstated Certificate will cover only a Disability resulting from a covered Accident or covered Sickness that occurs after the date the Certificate is reinstated.

In all other respects, the rights of all parties will remain the same, subject to any provisions noted on or attached to the reinstated Certificate. The statements in Your enrollment form for the reinstated Certificate will be measured from the date of reinstatement with respect to the time periods stated in Time Limit on Certain Defenses provision.

MISSTATEMENT OF AGE
If Your age has not been stated correctly, an adjustment in premium, coverage, or both, will be made. The adjustment will correct the coverage to what the premium paid would have bought at Your true age. This change will be based on our rates in effect on the Certificate Effective Date.

BENEFICIARY
The Beneficiary for benefits payable upon the Insured's death will be the Beneficiary named in the Certificate enrollment form, unless You have changed the Beneficiary designation. Unless specifically designated as irrevocable, You may change the Beneficiary designation while the Insured is living by written notice satisfactory to Us. An irrevocable Beneficiary designation may only be changed with the consent of such irrevocable Beneficiary. Unless You specify otherwise, the Beneficiary change will take effect as of the date the written notice was signed by You, subject to any payment or other action taken by Us prior to receipt of such notice. The consent of any Beneficiary, other than an irrevocable Beneficiary, is not required to surrender or assign this Certificate, or to make any other changes in this Certificate.

If any Beneficiary dies before the Insured, that Beneficiary's interest will pass to any other designated Beneficiaries according to their respective interests. If more than one Beneficiary is designated in a class, each Beneficiary who survives the Insured will receive an equal portion of any benefits payable unless otherwise set forth in the Beneficiary designation.

ASSIGNMENT
You can assign any rights You have under this Certificate, however, if You have designated an irrevocable Beneficiary, the consent of such Beneficiary is required to assign any rights. No assignment is binding on Us until We receive a copy of it. Each assignment will be subject to any payments made or action taken by Us before We received such assignment. We are not responsible for the validity of any assignment.

PHYSICAL EXAMINATION AND AUTOPSY
We have the right to have You examined when and as often as is reasonable during the handling of a claim and do an autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at Our expense.

CONFORMITY WITH STATE STATUTES
Any provision of this Certificate which, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

NOTICE
If there are any questions about this Certificate or if You need to obtain information about coverage or require assistance in resolving issues, please contact a Combined Insurance Company of America agent or the Home Office of the Company at the telephone number provided on the face page of this Certificate. All inquiries should be in writing, stating the Certificate Number.

Combined Insurance Company of America
A Legal Reserve Stock Corporation
(herein called Combined, We, Our or Us)

Home Office: 111 East Wacker • Suite 700 • Chicago, Illinois 60601
Policyholder Service Center: P. O. Box 1160 • Glenview, IL 60025-8160
1-800-544-9382

SURVIVOR BENEFIT RIDER

RIDER SCHEDULE

Covered Person: **Insured**

This Rider is attached to and forms part of the Group Disability Income Insurance Certificate ("Certificate"). This Rider was issued on the basis that the information provided by the Policyholder and any information provided by You are correct and complete.

This Rider is subject to all the terms, conditions, exclusions and limitations of the Certificate except as otherwise stated herein.

DEFINITIONS
For the purpose of this Rider only, the following terms are defined as follows:

Eligible Dependent means a person who is Your natural child, legally adopted child, child in the waiting period prior to finalization of adoption by the Insured, or step-child; provided that such child is unmarried and under age 26.

Eligible Survivor means Your Spouse, if living. Otherwise, it means Your Eligible Dependent child(ren) under age 26 years. An Eligible Survivor must be living at the time of Your death.

Spouse the person to You are legally married or Your Domestic Partner/Partner in a Civil Union.

SURVIVOR BENEFIT
We will pay a Survivor Benefit to Your Eligible Survivor when We receive proof that you died while this Rider is in force and You were:

1) Disabled for 30 or more consecutive days; and
2) Receiving or eligible to receive a disability benefit under the Certificate.

The Survivor Benefit will be payable as a lump sum equal to 3 times Your disability benefit.

If the Survivor Benefit is payable to Your Eligible Dependent child(ren) and, if there is more than one such Dependent child, then the Survivor Benefit will be divided equally among such Dependent children.

If there are no Eligible Survivors, the Survivor Benefit will be paid to Your estate. We will first apply the Survivor Benefit to recover any overpayments that may exist on Your claim.

ADVANCED SURVIVOR BENEFIT
We will pay an Advanced Survivor Benefit prior to Your death if this Rider is in force, you have been diagnosed as terminally ill, and:

1) You are receiving or are eligible to receive disability benefits;
2) Your Disability has continued for 180 or more consecutive days;

3) You are certified by a Physician to be terminally ill with a life expectancy of twelve (12) months or less.

The Advanced Survivor Benefit will be payable as a lump sum of 3 times Your Disability Benefit.

If You receive an Advanced Survivor Benefit, then no Survivor Benefit will be payable to Your Eligible Survivor.

This Rider will terminate on the earliest of the following:

1. The date the Certificate to which this Rider is attached terminates; or
2. The date Your coverage terminates.

No other Policy or Certificate provision or condition is changed in any way by this Rider, except as described above.

For Combined Insurance Company of America

Kevin Goulding, President

Rebecca L. Collins, Secretary

COMBINED INSURANCE®

FACTS

WHAT DOES COMBINED INSURANCE COMPANY OF AMERICA DO WITH YOUR PERSONAL INFORMATION?

Why?

Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and payment history
- insurance claim history and medical information
- account transactions and credit scores

When you are no longer our customer, we continue to share information about you as described in this notice.

How?

All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons Combined chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Combined share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies —	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	No	We don't share
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

To limit our sharing

☏ Call 1-800-544-9382 — our menu will prompt you through your choices

Please note:

If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice.

However, you can contact us at any time to limit our sharing.

Questions?

Call 1-800-544-9382 or go to www.combinedinsurance.com

What we do

How does Combined protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.
How does Combined collect my personal information?	We collect your personal information, for example, when you: • apply for insurance or pay insurance premiums • file an insurance claim or provide account information • give us your contact information We also collect your personal information from others, such as credit bureaus, affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • sharing for affiliates' everyday business purposes—information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your policy.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • *Our affiliates include the Combined Life Insurance Company of New York, and other financial companies.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • *Nonaffiliates we share with can include insurance companies and direct marketing companies.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • *Our joint marketing partners include categories of companies such as insurance companies.*

Other important information

For Insurance Customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR, and VA only: Under state law, you have the right to see the personal information about you that we have on file. To see your information, write Combined Insurance, Attention: Privacy Officer, PO Box 1160, Glenview, IL 60025-8160. Combined may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For California Residents Only: Your state law requires financial institutions to obtain your consent prior to sharing information about you with non-affiliated third parties while you are resident of California.

For Nevada Residents Only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by **calling 1-800-544-9382**, emailing us at combinedinsurance.com, or writing to Combined Insurance, Attention: Privacy Officer, PO Box 1160, Glenview, IL 60025-8160. You are being provided this notice under Nevada state law. In addition to contacting Combined, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont Residents Only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

Combined Insurance Worksite Solutions
A unit of Combined Insurance Company of America
An ACE Limited Company
CLAIM DEPARTMENT: P.O. Box 6700 • Scranton, PA 18505-0700
1-800-544-9382 • 312-351-6930 Fax

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claim or Policy Number: _____

Name: _____

Address: _____

Birthdate: _____

This will authorize WORKSITE SOLUTIONS, a unit of COMBINED INSURANCE COMPANY OF AMERICA, PO Box 6700, Scranton, PA 18505-0700 to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated.

The information to be disclosed may include but is not limited to:

History of Present Illness	Consultant's Reports	Discharge Summary
Operative Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Other (Specify):	

The information is needed for the following purpose(s):
Evaluation and processing of my insurance claim

- I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

- I understand that upon fulfillment of the above stated purposes, this consent will automatically expire six (6) months following date of signature without any express revocation. I understand I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Insurance Company of America. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or evaluate my insurance application for coverage.

  Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

_____ Date: _____
(Signature of Patient or Guardian) (Must be filled in)

_____ _____
(Signature of Witness) (Relationship to Patient If Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.