YOUR GROUP **MONTHLY DISABILITY INCOME** INSURANCE PLAN

For Management Employees of
Modesto City Schools

GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South
Minneapolis, Minnesota 55401

POLICYHOLDER:	Modesto City Schools
GROUP POLICY NUMBER:	71765-7 LTD2011
POLICY EFFECTIVE DATE:	January 1, 2021
GOVERNING JURISDICTION:	California

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the group policy listed above to the **Policyholder.** The policy is available for **you** to review if **you** contact the **Policyholder** for more information. **This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate of Coverage replaces any other certificates ReliaStar Life may have given **you** under the policy.

The Certificate of Coverage summarizes and explains the parts of the policy which apply to **you.** The Certificate of Coverage is part of the group policy but by itself is not a policy. **Your** coverage may be changed under the terms and conditions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security **Act** of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the policy, all days begin at 12:01 a.m. standard time at the **Policyholder's** address and end at 12:00 midnight standard time at the **Policyholder's** address.

The policy does not replace or affect any requirements for coverage by any Workers' Compensation or state disability insurance.

Registrar

CONSUMER NOTICE

IF YOU HAVE A QUESTION ABOUT YOUR POLICY, IF YOU NEED ASSISTANCE WITH A PROBLEM, OR IF YOU HAVE QUESTIONS ABOUT A CLAIM, YOU MAY WRITE OR CALL US AT:

ReliaStar Life Insurance Company

P.O. Box 20

Minneapolis, Minnesota 55440

Telephone Number: (800) 955-7736

YOU WILL NEED TO PROVIDE YOUR POLICY NUMBER WITH ANY COMMUNICATION.

IF YOU DO NOT REACH A SATISFACTORY RESOLUTION AFTER HAVING DISCUSSIONS WITH US, OR OUR AGENT OR REPRESENTATIVE, OR BOTH, YOU MAY CONTACT THE FOLLOWING UNIT WITHIN THE DEPARTMENT OF INSURANCE THAT DEALS WITH CONSUMER AFFAIRS:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

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RELIASTAR LIFE INSURANCE COMPANY

OUTLINE OF COVERAGE

This outline is only a summary of certain provisions in your Certificate of Coverage. You must consult the policy and certificate for contract provisions regarding coverage.

Disability Income Protection Coverage

	Section(s) of Certificate
BENEFITS	**Benefits At A Glance** **Long Term Disability Benefit Information**
EXCEPTIONS, REDUCTIONS AND LIMITATIONS	**Long Term Disability Benefit Information**
ELIGIBILITY, TERMINATION AND CONTINUATION	**General Provisions**

BENEFITS AT A GLANCE

The Long Term **Disability** policy provides benefits to replace a portion of **your** income while **you** are **disabled.** The amount **you** receive is based on the amount **you** earned before **your disability** began, subject to all policy provisions.

You must write **your** name and the date **you** received this certificate in the space provided so that it becomes **your** Certificate of Coverage. The date **you** are eligible for coverage is described in the GENERAL PROVISIONS section.

EMPLOYEE NAME:	
DATE RECEIVED:	
EMPLOYER:	Modesto City Schools
GROUP POLICY NUMBER:	71765-7 LTD2011

ELIGIBLE CLASS(ES)
All Management **employees** in **active employment** with the **Employer** in the United States.

You must be an **employee** of the **Employer** and in an eligible class.

Employees who are not citizens or legal residents of the United States are excluded from coverage.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
20 hours per week

WAITING PERIOD
For persons in an eligible class on or before the policy effective date: End of the month in which **you** complete a continuous period of 30 days of **active employment.**

For persons entering an eligible class after the policy effective date: End of the month in which **you** complete a continuous period of 30 days of **active employment.**

WHO PAYS FOR THE COVERAGE
You pay the cost of **your** coverage.

WAIVER OF PREMIUM
We do not require premium payments for **your** coverage and while **you** are receiving or are entitled to receive Long Term **Disability** payments under the policy.

ELIMINATION PERIOD
The latest of the following:
- 90 consecutive days for **disability** due to **injury.**
- 90 consecutive days for **disability** due to **sickness.**
- The date **your salary continuation or accumulated sick leave** payments end, if applicable.

The **elimination period** begins on the first day of **your disability.**

Benefits for a **payable claim** begin the day after the **elimination period** is completed.

ACCUMULATION OF ELIMINATION PERIOD
Accumulation period: 180 consecutive days.

The **elimination period** and the accumulation period begin on the first day of **your disability.**

Benefits for a **payable claim** begin the day after the **elimination period** is completed.

MONTHLY BENEFIT
60% of **pre-disability earnings** to a **maximum benefit** of $8,500 per month.
Your benefit may be reduced by any **benefit reductions** and **disability earnings.**

BENEFITS AT A GLANCE

Some **disabilities** may not be covered or may have limited coverage under the policy.

PRE-DISABILITY EARNINGS
Pre-disability earnings means **your** gross monthly income from **your Employer** in effect just prior to **your** date of **disability.** It includes **your** total income before taxes, and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than **your Employer.**

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the **monthly payment.**

MAXIMUM PERIOD OF PAYMENT
For a **disability** which begins before **you** reach age 60, the **maximum period of payment** will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	Social Security Normal Retirement Age (SSNRA)*
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 and after	67 years

For a **disability** which starts on or after **you** reach age 60, the **maximum period of payment** will be determined according to the following table:

Your Age When Disability Begins	Maximum Period of Payment
Age 60	60 months or to SSNRA*, whichever is greater
Age 61	48 months or to SSNRA*, whichever is greater
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*Age at which **you** are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

TOTAL BENEFIT CAP
If **you** are eligible to receive payments under the policy in addition to **your monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your pre-disability earnings.** However, if **you** are participating in a **vocational rehabilitation**

plan, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your pre-disability earnings.**

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

DEFINITIONS

ACTIVE EMPLOYMENT means **you** are working for **your Employer** for earnings that are paid regularly. **You** must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.

To be in **active employment, your** work site must be one of the following:
- **Your Employer's** usual place of business.
- An alternative work site at the direction of **your Employer,** including **your** home.
- A location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment.**
Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that both of the following are true:
- **You** visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your disabling** condition(s).
- **You** receive care or treatment appropriate for the **disabling** condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is appropriate for the **disabling** condition(s) according to standard medical practice.

BENEFIT REDUCTIONS means income from other sources as listed in the certificate which **you** receive while **you** are **disabled.** This income will be subtracted from **your gross monthly payment.**

CHILD means a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of **your registered** or **non-registered domestic partner** or a person for whom you have legal responsibility to take on the functions and responsibilities of a parent.

DISABILITY or **DISABLED** or **DISABLING** means **you** are **totally disabled** or **residually disabled.**

DISABILITY EARNINGS means the earnings which **you** receive while **you** are **residually disabled** and working.

Disability earnings does not include earnings from secondary employment if such employment began prior to **your** date of **disability.**

DOCTOR means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:
- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the **laws** and regulations of the jurisdiction where treatment occurred.

We will not recognize **you** or **your** family members, including but not limited to: spouse, **registered domestic partner,** children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as a **doctor** for a claim that **you** send to **us.**

ELIGIBLE SURVIVOR means **your** spouse or **registered domestic partner** if living, otherwise, **your** children under age 26.

ELIMINATION PERIOD means the period of continuous **disability you** must satisfy before **you** are eligible to receive benefits under the policy. The **elimination period** begins on the first day of **your disability.**

For an **elimination period** more than 90 days, **we** will consider **your disability** to be continuous if **your disability** stops during the **elimination period** for 30 days or less.

For an **elimination period** of 90 days, **we** will consider **your disability** to be continuous if **your disability** stops during the **elimination period** for 14 days or less.

DEFINITIONS

For an **elimination period** of 31 to less than 90 days, **we** will consider **your disability** to be continuous if **your disability** stops during the **elimination period** for 7 days or less for each 31 days of **elimination period.**

If **your elimination period** is less than 31 days, and **your disability** stops during the **elimination period, we** will not consider **your disability** to be continuous.

The days that **you** are not **disabled** will not count toward **your elimination period.**

EMPLOYEE means a person in **active employment** with the **Employer** in the United States.

EMPLOYER means the **Policyholder** and includes any division, subsidiary or affiliated company named in the policy.

GRACE PERIOD means the 60 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder.**

GROSS MONTHLY PAYMENT means **your** benefit before any reduction for **benefit reductions** and **disability earnings.**

HOSPITAL, HEALTH FACILITY or INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing **your disability.**

INDEXED PRE-DISABILITY EARNINGS means **your pre-disability earnings** adjusted on each anniversary of benefit payment by the current annual percentage increase in the Consumer Price Index. **Your indexed pre-disability earnings** may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. **We** reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are **disabled** and working.

INJURY means physical harm or damage to the body. **Injury** that occurs before **you** are covered under the policy will be treated as a **sickness.**

INSURED PERSON means any person covered under the policy.

LAW, PLAN or **ACT** means the original enactments of the law, plan or act and all amendments.

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. Your** normal vacation time or any period of **disability** is not considered a **leave of absence.**

MAXIMUM BENEFIT means the total monthly benefit amount for which **you** are insured under the policy subject to all policy provisions.

MAXIMUM PERIOD OF PAYMENT means the longest period of time **we** will make payments to **you** for any one period of **disability.**

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a **disability.** 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.** Severe **mental illness** includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders (including postpartum depression), panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

MONTHLY PAYMENT means **your** benefit after any **benefit reductions** and **disability earnings** have been subtracted from **your gross monthly payment.**

PAYABLE CLAIM means a claim for which **we** are liable under the terms of the policy.

POLICYHOLDER means the **Employer** to whom the policy is issued and who sponsors the coverage for its **employees.**

DEFINITIONS

PRE-DISABILITY EARNINGS means **your** gross monthly income from **your Employer** as stated in the BENEFITS AT A GLANCE.

PRE-EXISTING CONDITION means that:

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 **your** coverage under the policy, or
   - suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was mispresented or not disclosed in **your** application (i) for which **you** received a **doctor's** advice or treatment within 3 months before the effective date of **your** coverage, or (ii) which caused symptoms within 3 months before the effective date of **your** coverage for which a prudent person would usually seek medical advice or treatment, and
2. The **disability** caused or substantially contributed to by the condition begins in the first 12 months after **your** effective date of coverage under the policy.

RECURRENT DISABILITY means a **disability** for which both of the following are true:
- It is caused by a worsening in **your** condition.
- It is due to the same cause(s) as **your** prior **disability** for which **we** made a **monthly payment.**

REGISTERED DOMESTIC PARTNER means the person named in **your** declaration of domestic partnership that has been filed with the Secretary of State of California.

RESIDUAL DISABILITY and **RESIDUALLY DISABLED** means that during the first 24 months of payments **you** are not **totally disabled** and that while actually working in **your usual occupation,** as a result of **sickness** or **injury, you** are unable to earn 80% or more of **your indexed pre-disability earnings.**

After 24 months of payments, **residual disability** and **residually disabled** means **you** are not **totally disabled** and that 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, station in life, and physical and mental capacity.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to **insured persons** and are not funded entirely by **insured person** contributions. **Retirement plan** includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

SALARY CONTINUATION or ACCUMULATED SICK LEAVE means continued payments to **you** by **your Employer** of all or part of **your pre-disability earnings,** after **you** become **disabled** as defined by the policy. This continued payment must be part of an established plan maintained by **your Employer,** and includes **salary continuation or accumulated sick leave** or any similar **Employer** sponsored paid time off plan.

SICKNESS means illness, disease or physical condition. **Disability** resulting from the **sickness** must begin while **you** are covered under the policy.

SUBSTANTIAL AND MATERIAL ACTS means acts that are normally required for the performance of **your usual occupation** and cannot be reasonably omitted or modified.

TOTAL DISABILITY and **TOTALLY DISABLED** means that as a result of **sickness** or **injury you** are unable to perform with reasonable continuity the **substantial and material acts** necessary to pursue **your usual occupation** and **you** are not working in **your usual occupation.**

After 24 months of payments, **total disability** and **totally disabled** means that as a result of **sickness** or **injury you** are not able to engage with reasonable continuity in any 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 that exists within any of the following locations:

DEFINITIONS

- A reasonable distance or travel time from **your** residence in light of the commuting practices of **your** community.
- A distance or travel time equivalent to the distance or travel time **you** traveled to work before becoming **disabled.**
- The regional labor market, if **you** reside or resided prior to becoming **disabled** in a metropolitan area.

USUAL OCCUPATION means any employment, business, trade or profession **you** were regularly performing for **your Employer** when the **disability** began. **Usual occupation** is not necessarily limited to the specific job **you** performed for **your Employer.**

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by **us,** prepares in accordance with the VOCATIONAL REHABILITATION BENEFIT provision of the certificate.

WAITING PERIOD means the continuous period of time (shown in the BENEFITS AT A GLANCE) that **you** must be in **active employment** in an eligible class before **you** are eligible for coverage under the policy.

WE, US and **OUR** means ReliaStar Life Insurance Company.

YOU and **YOUR** means a person who is eligible for coverage under the policy.

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include riders, endorsements and/or amendments. It tells **you:**

- The coverage to which **you** may be entitled.
- To whom **we** will make a payment.
- The limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of the following:

- The policy effective date.
- The day after **you** complete **your** waiting period.

WHEN COVERAGE BEGINS

When the **Policyholder** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. standard time at the **Policyholder's** address on the date **you** are eligible for coverage.

In order for **your** coverage to begin, **you** must be in **active employment. Your** coverage is subject to payment of premium.

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **leave of absence.** If **you** are not in **active employment** due to **injury** or **sickness,** any increased or additional coverage will begin on the date **you** return to **active employment.**

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence,** and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment,** limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of disability coverage during an FMLA or State FML **leave of absence, your** coverage will be continued until the end of the later of:

- The leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments.
- The leave period permitted by applicable state **law.**

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence,** and if premium is paid, **your** coverage will be continued through the end of the 3 months that immediately follows the month in which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law, your** coverage may be continued until the end of the later of:

- The length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence.**
- The length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence.**

GENERAL PROVISIONS

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment, we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence,** and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence, your** coverage will be reinstated. **We** will not apply a new **waiting period,** or require **evidence of insurability,** or apply a new **pre-existing condition** limitation.

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment, your** coverage may be reinstated in accordance with USERRA and applicable state **law.**

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of the following dates:
• The date the policy is canceled.
• The date **you** are no longer in an eligible class.
• The date **your** eligible class is no longer covered.
• The end of the **grace period** after a premium due date, if premium is not paid.
• The last day **you** are in **active employment** except as provided under a covered **leave of absence**.
Cancellation of **your** coverage will be without prejudice to any **disability** which begins prior to the effective date of such cancellation.

LEGAL ACTIONS

No action at **law** or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the 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.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the **Policyholder** and **you** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless both of the following are true:
• The statement is in writing and is signed by **you.**
• A copy of that statement is given to **you** or **your** beneficiary, or **your** personal representative.

TIME LIMIT ON CERTAIN DEFENSES

After two years from **your** effective date of coverage under the policy, no misstatements, except fraudulent misstatements made by **you** in **your** application for coverage shall be used to contest your coverage or to deny a claim for loss incurred or **disability** commencing after the expiration of the two-year period.

No claim for loss incurred or **disability** commencing after two years from the effective date of **your** coverage shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of **your** coverage.

CLERICAL ERROR

Clerical error or omission by **us** or by the **Policyholder** will not:
• Prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy.
• Cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

If the **Policyholder** gives **us** information about **you** that is incorrect, **we** will do both of the following:
• Use the facts to decide whether **you** have coverage under the policy and in what amounts.

• Make a fair adjustment of the premium.

MISSTATEMENT OF AGE
If **your** age has been misstated, all amounts payable to **you** under the policy shall be such as the premium paid would have purchased at the correct age.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE
The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY
For purposes of the policy, the **Policyholder** acts on its own behalf or as **your** agent. Under no circumstances will the **Policyholder** be deemed **our** agent.

NOTICE OF CLAIM
Written notice of claim must be given to **us** within 30 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 **you** or the claimant to **us** at P.O. Box 20, Minneapolis, MN 55440 or to **our** authorized agent, with information sufficient to identify the **insured person,** shall be deemed notice to **us.**

CLAIM FORMS
Upon receipt of a notice of claim, **we** or the **Employer** will furnish to **you** such forms as are usually furnished by **us** for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, **you** shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for providing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS
Written proof of loss must be furnished to **us,** in case of claim for loss for which the 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 submit 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 **your** legal capacity, later than one year from the time proof is otherwise required.

EVIDENCE OF CONTINUING DISABILITY
Once **we** approve **your** claim **you** will be asked to provide evidence of continuing **disability** at reasonable intervals based on **your** condition. Evidence of continuing **disability** means documentation of **your** condition that is sufficient to allow **us** to determine if **you** are still **disabled.** Upon request, **you** will be asked to provide evidence of continuing **disability** within 45 days. If evidence is not provided within that period of time, **we** will contact **your doctor** in an effort to obtain the necessary documentation. If **you** do not submit evidence of continuing **disability** and **we** are unable to obtain the necessary documentation from **your doctor** or from a reasonably requested examination by a **doctor** of **our** choice, **your** payments will end. Upon receipt of evidence of continuing **disability,** benefit payments will resume subject to the terms of the policy. **We** will send **you** a payment for any period for which **we** are liable. **You** or **your Employer** must notify **us** immediately when **you** return to work in any capacity.

TIME OF PAYMENT OF CLAIM
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 monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

GENERAL PROVISIONS

PAYMENT OF CLAIMS

Indemnities for loss for which the policy provides periodic payment will be payable to **you.** Indemnity for loss of life will be payable to **your eligible survivor.**

PHYSICAL EXAMINATIONS

At **our** expense, **we** shall have the right and opportunity to require **you** to be examined as it relates to the **injury** or **sickness** that is the basis of **your** claim. **We** can require such examination when and as often as **we** may reasonably require during the pendency of a claim.

LONG TERM DISABILITY BENEFIT INFORMATION

WHEN BENEFITS ARE PAYABLE UNDER THE POLICY

If **you** are **disabled, you** are eligible to receive a benefit under the policy, subject to the provisions described in this Certificate of Coverage.

You will begin to receive payments when **we** approve **your** claim, providing the **elimination period** has been met and **you** are **disabled. We** will send **you** a **monthly payment** at the end of each month for any period for which **we** are liable.

After the **elimination period,** if **you** are **disabled** for less than 1 month, **we** will send **you**1/30th of **your monthly payment** for each day of **your disability.**

ACCUMULATION OF ELIMINATION PERIOD

You must be continuously **disabled** through **your elimination period. Your elimination period** is as stated in the BENEFITS AT A GLANCE and is the period of continuous **disability you** must satisfy before **you** are eligible to receive benefits under the policy.

If **you** return to work while satisfying **your elimination period, you** may satisfy **your elimination period** within the accumulation period. The accumulation period is as stated in the BENEFITS AT A GLANCE.

The days that **you** are not **disabled** will not count toward **your elimination period.**

If **you** do not satisfy the **elimination period** within the accumulation period, a new period of **disability** will begin.

The **elimination period** and the accumulation period begin on the first day of **your disability.**

Benefits for a **payable claim** begin the day after the **elimination period** is completed.

AMOUNT OF PAYMENT

A. IF YOU ARE TOTALLY DISABLED

We will follow this process to figure **your** payment:

1. Multiply **your pre-disability earnings** by 60%.
2. The **maximum benefit** is $8,500 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**
4. Subtract from **your gross monthly payment** any **benefit reductions.**

The amount figured in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

B. IF YOU ARE RESIDUALLY DISABLED AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED PRE-DISABILITY EARNINGS

If **you** are **residually disabled** and **your disability earnings** are less than 20% of **your indexed pre-disability earnings, we** will not reduce **your** monthly benefit by **your disability earnings.**

Your monthly payment will be calculated as if **you** are **totally disabled.**

C. IF YOU ARE RESIDUALLY DISABLED, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN 80% OF YOUR INDEXED PRE-DISABILITY EARNINGS

During the first 12 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed pre-disability earnings.** If the sum exceeds 100% of **your indexed pre-disability earnings, we** will reduce **your** payment under the policy by the excess amount.

LONG TERM DISABILITY BENEFIT INFORMATION

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed pre-disability earnings, we** will follow this process:

1. Multiply **your pre-disability earnings** by 60%.
2. The **maximum benefit** is $8,500 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**
4. Add **your disability earnings** to **your gross monthly payment.**

If the answer in Step 4 above is less than or equal to 100% of **your indexed pre-disability earnings, your monthly payment** will be **your gross monthly payment** minus any **benefit reductions.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

If the answer in Step 4 above is greater than 100% of **your indexed pre-disability earnings, we** will follow this process to figure **your monthly payment:**

a. Add **your disability earnings** to **your gross monthly payment.**
b. From the answer in Step a, subtract **your indexed pre-disability earnings.** If the result is zero or less, record **your** answer as zero.
c. From **your gross monthly payment,** subtract the answer in Step b and any **benefit reductions.**

The amount figured in Step c is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

After 12 months of **monthly payments, you** will receive payments based on the percentage of income **you** are losing due to **your disability. We** will follow this process to determine **your monthly payment:**

1. Subtract **your disability earnings** from **your indexed pre-disability earnings.**
2. Divide the answer in Step 1 by **your indexed pre-disability earnings.** The result is **your** percentage of lost earnings.
3. From **your gross monthly payment,** subtract any **benefit reductions.**
4. Multiply the answer in Step 2 by the answer in Step 3.

The answer in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

D. IF YOUR DISABILITY EARNINGS ARE EQUAL TO OR EXCEED 80% OF YOUR INDEXED PRE-DISABILITY EARNINGS

If **you** are working and **your disability earnings** are equal to or exceed 80% of **your indexed pre-disability earnings,** no benefit will be payable.

We may require **you** to send proof of **your** monthly **disability earnings** each month. **We** will adjust **your** payment based on **your** monthly **disability earnings.**

As part of **your** proof of **disability earnings, we** can require that **you** send **us** appropriate financial records that **we** believe are necessary to substantiate **your** income.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If **your disability earnings** routinely fluctuate widely from month to month, **we** may average **your disability earnings** over the most recent three months to determine if **your** claim should continue.

If **we** average **your disability earnings, we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months are equal to or exceed 80% of **your indexed pre-disability earnings.**

We will not pay **you** for any month during which **your disability earnings** exceed the amount allowable under the policy. In no event will benefits be paid beyond the **maximum period of payment.**

LONG TERM DISABILITY BENEFIT INFORMATION

WE WILL NEVER PAY MORE THAN 100% OF PRE-DISABILITY EARNINGS

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your pre-disability earnings.** However, if **you** are participating in a **vocational rehabilitation plan,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your pre-disability earnings.**

BENEFIT REDUCTIONS

With the exception of retirement payments, **we** will only subtract **benefit reductions** which are paid as a result of the same **disability.** The following are **benefit reductions:**

- The amount that **you** receive as disability income payments under any:
  - State compulsory benefit **act** or **law.**
  - Governmental retirement system as a result of **your** job with **your Employer.**
- The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones **Act**).
- Third party liability payments by judgment, settlement or otherwise (less attorney's fees).
- Amounts received by compromise or settlement of any claim for permitted offsets (less attorney's fees).
- The amount **you** receive under any **salary continuation or accumulated sick leave** plan.
- The amount that **you** receive from **your Employer** for personal time off.
- Annual leave pay.
- The amount that **you:**
  - receive as disability payments under **your Employer's retirement plan;**
  - voluntarily elect to receive as retirement payments under **your Employer's retirement plan.**

  Disability payments under a **retirement plan** will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

  Retirement payments will be those benefits which are paid based on **your Employer's** contribution to the **retirement plan.** Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

  Regardless of how the retirement funds from the **retirement plan** are distributed, **we** will consider the **Employer** and **insured person** contributions to be distributed simultaneously throughout **your** lifetime.

  Amounts received do not include amounts rolled over or transferred to any eligible **retirement plan. We** will use the definition of eligible **retirement plan** as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
- The amount that **you, your** spouse and **your** children receive as disability payments because of **your** disability under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **Plan** or **Act.**
- The amount that **you** receive as retirement payments under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **Plan** or **Act.**

  We will not offset with any retirement amount received by **your** spouse or dependents.

- a. During the first 12 months of payments, the amount **you** earn or receive from employment, but only to the extent that **your gross monthly payment** and **disability earnings** exceed 100% of **your indexed pre-disability earnings. We** will subtract the amount in excess of 100% from **your gross monthly payment.**

  b. After 12 months of payments, **we** may reduce **your gross monthly payment** by the amount **you** earn or receive from employment.

  Only those earnings from work **you** perform for **your Employer,** or earnings from another employer for which **you** become employed after **your disability** begins, will be counted as earnings under the above items a and b. Refer to the AMOUNT OF PAYMENT provision for further details on how **we** will calculate **your monthly payment.**

- The amount that **you** receive as either of the following:
  - Temporary disability benefits under a workers' compensation **law.**
  - Disability benefits under any other occupational disease **law** or similar **act.**

COST OF LIVING INCREASES FROM BENEFIT REDUCTIONS

Other than for increases in any income **you** earn from work **you** perform for **your Employer,** or earnings from another employer for which **you** become employed after **your disability** begins, once **we** have subtracted any **benefit reductions** from **your gross monthly payment, we** will not further reduce **your** payment due to a cost of living increase from that source.

WE MAY ESTIMATE YOUR ENTITLEMENT TO PAYMENTS FROM OTHER SOURCES

If **you** qualify for benefits from any of the following sources, **you** must apply for such benefits and pursue them with reasonable diligence:

- Disability income payments under any state compulsory benefit **act** or **law.**
- Disability payments for **you** and **your** spouse and **your** children because of **your** disability under any of the following:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **plan** or **act.**
- Disability payments as a result of any action brought under Title 46, United States Code Section 688 (The Jones **Act**).

We will estimate **your** entitlement to these benefits, and **we** can reduce **your** benefit under the policy by the estimated amounts, if **we** have a reasonable, good faith belief that **you** are entitled to such benefits and a means of reasonably estimating the amount payable, and either of the following is also true:

- **You** do not apply for such benefits.
- **You** have failed to pursue the benefits with reasonable diligence.

If **your gross monthly payment** has been reduced by an estimated amount, **your gross monthly payment** will be adjusted when **we** receive proof of either of the following:

- The amount awarded.
- That benefits have been denied and all appeals have been completed. In this case, a lump sum refund of the estimated amount will be made to **you.**

If **you** receive a lump sum payment from any **benefit reductions,** the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime.

LONG TERM DISABILITY BENEFIT INFORMATION

INCOME WHICH WILL NOT REDUCE YOUR BENEFITS

We will not subtract from **your gross monthly payment** income **you** receive from the following:

- 401(k) plans.
- Profit sharing plans.
- Thrift plans.
- Tax-sheltered annuities.
- Stock ownership plans.
- Credit disability insurance.
- Non-qualified plans of deferred compensation.
- Pension plans for partners.
- Military pension plans.
- Franchise disability income plans.
- Individual disability plans.
- A retirement plan from another employer.
- Individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is the greater of:

- $100.
- 10% of **your gross monthly payment.**

We may apply this amount to recover any outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment. Your maximum period of payment** is stated in the BENEFITS AT A GLANCE, will be paid during a continuous period of **disability,** and will be based on **your** age at **disability.**

WHEN PAYMENTS END

We will stop sending **you** payments on the earliest of the following:

- The end of the **maximum period of payment.**
- The date **you** are no longer **disabled** under the terms of the policy.
- The date **you** fail to submit proof of continuing **disability,** according to the terms of the EVIDENCE OF CONTINUING DISABILITY provision.
- The date **you** are no longer under the **appropriate care** of a **doctor.**
- The date **you** die.
- The date **your disability earnings** are equal to or exceed 80% of **your indexed pre-disability earnings.**

We will not pay a benefit for any period of **disability** during which **you** are incarcerated after being convicted of a crime.

OVERPAID CLAIMS

We have the right to recover any overpayments due to any of the following:

- Fraud.
- Any administrative error **we** make in processing a claim.
- **Your** receipt of **benefit reductions.**

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **We** will not recover more money than the amount **we** paid **you.** However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable **disability** claim under the policy.

LONG TERM DISABILITY BENEFIT INFORMATION

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any **disabilities** caused by, substantially contributed by, or resulting from **your:**

- Commission of or attempt to commit a felony.
- Intentionally self-inflicted injuries.
- Attempted suicide, regardless of mental capacity.
- Being legally intoxicated or being under the influence of any controlled substance unless administered on the advice of a **doctor.**
- Participation in a war, declared or undeclared, or any act of war.
- Active military duty.
- Active participation in a riot.
- Engaging in any illegal occupation.
- Traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING CONDITION LIMITATION

You are not covered for a **disability** caused or substantially contributed to by a **pre-existing condition** or medical or surgical treatment of a **pre-existing condition** if such **disability** begins in the first 12 months after **your** effective date of coverage under the policy.

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The lifetime cumulative **maximum period of payment** for all **disabilities** due to **mental illness,** alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such **disabilities** even if the **disabilities** are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still **disabled** when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be **disabled** after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment,** whichever occurs first.

We will not apply the **mental illness** limitation to a **disability** due to dementia if it is a result of stroke, trauma, viral infection or Alzheimer's disease.

We will not apply the drug abuse limitation to a **disability** due to drug abuse or dependency resulting from the use of a controlled substance administered on the advice of a **doctor.**

CONTINUITY OF COVERAGE

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the date **your Employer** changes insurance carriers to **our** policy, and **you** were covered under the prior policy at the time **your Employer's** coverage under **our** policy became effective, **we** will provide continuity of coverage under **our** policy. In order for this provision to apply, the prior policy's coverage must be similar to **our** policy.

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the effective date of **our** policy, and **you** would otherwise be eligible to become insured under **our** policy, **we** will provide limited coverage under **our** policy. Coverage under this provision will begin on **our** policy effective date and will continue until the earliest of the following:

- The date **you** return to **active employment.**
- The end of any period of continuance or extension provided under the prior policy.

• The date coverage would otherwise end, according to the provisions of **our** policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under **our** policy will apply.

CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITIONS

We may pay benefits if **your disability** is caused or substantially contributed to by a **pre-existing condition** if both of the following are true:

- **You** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy.
- **You** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your disability** began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under either **our** policy or under the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of **our** policy, but **you** do satisfy the prior policy's **pre-existing condition** provision, then both of the following apply:

- **Your monthly payment** will be the lesser of:
  - the **monthly payment** that would have been payable under the terms of the prior policy had it remained in force.
  - the **monthly payment** under **our** policy.
- Benefits will end on the earlier of:
  - the date benefits end under **our** policy, as described under the WHEN PAYMENTS END provision.
  - the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either **our** policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy. All other provisions of **our** policy will apply.

RECURRENT DISABILITY

If **you** have a **recurrent disability,** and after **your** prior **disability** ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your disability** as part of **your** prior claim and **you** do not have to complete another **elimination period.** Only one **maximum period of payment** will apply when **your disability** is considered part of **your** prior claim.

Your monthly payment will be based on **your pre-disability earnings** as of the date of **your** initial claim. **Your disability,** as outlined above, will be subject to the same terms of the policy as **your** prior claim.

Your disability will be treated as a new claim if either of the following is true:

- **Your** current **disability** is unrelated to **your** prior **disability.**
- After **your** prior **disability** ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new **elimination period.** A new **maximum period of payment** will apply.

If **our** policy terminates and **you** become eligible for coverage under any other group disability plan that replaces **our** policy, **you** will not be eligible for coverage under **our** policy.

LONG TERM DISABILITY BENEFIT INFORMATION

VOCATIONAL REHABILITATION BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** may be eligible for an additional Vocational Rehabilitation Benefit. **We** will pay an additional benefit of 10% of **your gross monthly payment** to a maximum of $1,000 per month.

Your participation in a **vocational rehabilitation plan** is voluntary. **Your** claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help **you** return to gainful employment. As **your** file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan. In order to be eligible for participation in a **vocational rehabilitation plan, you** must be medically able to participate in a return to work plan. If **we** determine that vocational rehabilitation services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you.**

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **benefit reductions.** However, the Total Benefit Cap will apply.

Vocational Rehabilitation Benefits will end on the earliest of the following dates:
- The date **you** are no longer eligible to participate in a **vocational rehabilitation plan.**
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

CHILD CARE EXPENSE BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** will be eligible for an additional **Child** Care Expense Benefit if **you** are incurring child care expenses for a **child** under age 15.

We will pay a **Child** Care Expense Benefit of $350 per **child** not to exceed a maximum of $1,000 per month.

The **Child** Care Expense Benefit will end on the earliest of the following dates:
- The date **you** are no longer incurring **child** care expenses.
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- After 12 months of **Child** Care Expense Benefits have been paid for each **child.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide proof that **you** are incurring **child** care expenses. Such proof includes **child** care expense invoices or payment receipts from a person or facility licensed to provide **child** care.

Child care means care or supervision of **your child** and care is given by a licensed child-care center or a licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount.However, the Total Benefit Cap will apply.

WORKPLACE MODIFICATION BENEFIT

If **you** are **disabled** and are receiving a payment under the policy from **us,** a Workplace Modification Benefit may be payable to **your Employer.** Subject to the maximum amount below, **we** will reimburse **your Employer** for 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** pay will not exceed the lesser of the following:
- Two times **your** last **monthly payment.**
- $2,000.

You must meet both of the following requirements:
- Be **disabled** according to the terms of the policy.
- Have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include all of the following:
- Input from the **Employer** and **you.**
- **Your doctor's** opinion that the modification is suitable for **your** condition.
- The purpose of the proposed workplace modification.
- The expected completion date of the workplace modification.
- The cost of the workplace modification.

We will reimburse the costs of the workplace modification when all of the following are true:
- **We** approve the proposal in writing.
- **We** receive proof from **your Employer** that the workplace modification is complete.
- **We** receive proof of the costs incurred by **your Employer** for the workplace modification.

The Workplace Modification Benefit is available on a one-time basis for each **insured person** under the policy.

SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your gross monthly payment** if, on the date of **your** death, both of the following are true:
- **Your disability** had continued for 180 or more consecutive days.
- **You** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors,** payment will be made to **your** estate.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.