

**CITY OF VICTORIA, TEXAS**

**REQUEST FOR COMPETITIVE SEALED  
PROPOSALS**

**For**

**LIFE AND DISABILITY INSURANCE**

**# RFP-TA-7232026-LDI**

Date Issued:

June 22, 2026



**RESPONSES MUST BE RECEIVED NO LATER THAN:  
10:00 AM CST JULY 23, 2026**

City of Victoria Purchasing Department:

Phone: 361-485-3170

Email: [purchasing@victoriatx.gov](mailto:purchasing@victoriatx.gov)

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**NOTICE TO RESPONDENTS**  
**REQUEST FOR COMPETITIVE SEALED PROPOSALS**  
**# RFP-TA-7232026-LDI**

The City of Victoria, (“the City”), intends to purchase and invites you to submit a sealed response for:

**LIFE AND DISABILITY INSURANCE**

Sealed Responses addressed to the Procurement Manager will be received until **July 23, 2026 at 10:00 AM CST**. All Responses must be in the City’s possession on or before the scheduled date and time (no late responses will be considered). **Documents are available at <https://www.bidnetdirect.com/texas/city-of-victoria>.**

In accordance with Chapter 252 of the Texas Local Government Code, the contract will be awarded to the Respondent who provides the best value to the City. The City shall evaluate the responses on the basis of all factors described herein.

The City reserves the right to refuse and reject any or all responses.

Responses will be received by electronic submission at Bid Net Direct – Texas Purchasing Group  
**<https://www.bidnetdirect.com/texas/city-of-victoria>**.

Thomas Anklam CTCM, CTCD  
Procurement Manager  
City of Victoria

# **PART I**

## **GENERAL REQUIREMENTS FOR RESPONSES**

### **1. DEVIATION FROM SPECIFICATION/ REQUIREMENTS**

Please read the requirements thoroughly and be sure that your response complies with all requirements/specifications noted. Any variation from the solicitation requirements/specifications must be clearly indicated by letter, on a point-by-point basis, attached to and made a part of your response. If no exceptions are noted, and you are the successful Respondent, the City of Victoria, (“the City”), will require that the service(s) be provided as specified.

### **2. GENERAL DESCRIPTION**

Pursuant to Chapter 252 of the Texas Local Government Code, the City invites the submittal of responses to this Request for Competitive Sealed Proposals (RFP) from qualified firms interested in providing Life and Disability Insurance.

### **3. PURPOSE**

The purpose of these specifications/requirements and response documents are to award a contract for the purchase of Life and Disability Insurance.

### **4. STAFF CONTACT**

Name: Nina Campos  
Phone # 361-485-3500  
Email: [ncampos@victoriatx.gov](mailto:ncampos@victoriatx.gov)

### **5. INTENT**

The service(s) to be provided under the RFP shall be in accordance with and shall meet all specifications and/or requirements as shown in this solicitation.

### **6. SUBMITTAL OF RESPONSES**

Responses shall be submitted electronically through <https://www.bidnetdirect.com/texas/city-of-victoria>, upload the Adobe PDF files of:

- Response Form A – Proposal Signature Page,
- Response Form B – Proposal Form,
- all other required forms, and;
- any Specifications that are required as part of the proposal.

Responses **WILL** be accepted electronically through Bid Net Direct. Responses **WILL NOT** be accepted via oral communication, telephone, electronic mail, telegraphic transmission, or facsimile transmission.

Responses may be withdrawn prior to the above scheduled time set for closing. Alterations made before response closing must be initiated by respondents guaranteeing authenticity. Submittal of a response constitutes an offer by the Respondent. Once submitted, the response becomes the



property of the City and as such the City reserves the right to use any ideas contained in any response regardless of whether that respondent/firm is selected.

Submission of a response in response to this solicitation, by any Respondent, shall indicate that the respondent(s) has accepted the conditions contained in the RFP, unless clearly and specifically noted in the response submitted and confirmed in the Contract between the City and the successful Respondent. Responses that do not comply with these requirements may be rejected at the option of the City. Responses must be filed with the City before the deadline day and hour. No late response will be accepted. They will be returned to Respondent unopened (if properly identified). Failure to meet response requirements may be grounds for disqualifying a Respondent.

## **7. PROPOSAL OPENING**

The City will be accepting sealed Proposals until **10:00 AM CST**, on **July 23, 2026** at which time they will be opened publicly and the name of the Respondent and the monetary component of the Proposals shall be read aloud. Any Proposal received after proposal time will be returned unopened. Receipt of response does not bind the City to any contract for said services, nor does it give any guarantee that a contract for the Project will be awarded.

## **8. ASSIGNMENT**

Respondents are advised that the City shall not allow the successful Respondent to sell, assign, transfer, or convey any part of any contract resulting from this response in whole or in part, to a third party without the written approval of the City.

## **9. PREPARATION OF RESPONSE**

Responses **MUST** give full firm name and address of Respondent, and be manually signed. Failure to do so will disqualify your submittal. The person signing the response must show title or **AUTHORITY TO BIND FIRM IN A CONTRACT**. Firm name and authorized signature must appear on each page that calls for this information. The legal status of the Respondent whether corporation, partnership, or individual, shall also be stated in the submittal. A corporation shall execute the submittal by its duly authorized officers in accordance with its corporate bylaws and shall also list the state in which it is incorporated. A partnership Respondent shall give full names and business addresses of all partners. All partners shall execute the submittal. Partnership and Individual Respondents shall state in the submittal the names and addresses of all persons with a vested interest therein. The place of residence of each Respondent, or the office address of the contractor, with county and state and telephone number, shall be given after the signature. Any costs associated with assembling this submittal will be at the sole expense of the Respondent.

## **10. WITHDRAWAL**

Responses may be withdrawn prior to the due date for submission. Written notice of withdrawal shall be provided to the Purchasing Supervisor for proposals submitted in hard copy. No response may be withdrawn after opening time without reasonable exception in writing and only after approval by the City.

## **11. TIME ALLOWED FOR ACTION TAKEN**

The City may hold responses 120 days after submittal deadline without taking action. Respondents are required to hold their responses firm for same period of time.

## **12. ALTERATIONS/AMENDMENTS TO RESPONSES**

Responses CANNOT be altered or amended after the opening deadline. Alterations made before opening time must be initialed by Respondent guaranteeing authenticity.

## **13. LIST OF EXCEPTIONS**

The Respondent shall attach to the response a list of any exceptions to the specifications/requirements, on a point-by-point basis.

## **14. NAME BRANDS**

Specifications may reference name brands and model numbers. It is not the intent of the City to restrict these responses in such cases, but to establish a desired quality level of merchandise or to meet a pre-established standard due to like existing items. Respondents may offer items of equal stature and the burden of proof of such stature rests with Respondents. The City shall act as sole judge in determining equality and acceptability of products offered.

## **15. INSPECTIONS & TESTING**

The City reserves the right to inspect any item(s) or service location for compliance with specifications and requirements and needs of the using department. If a Respondent cannot furnish a sample of a response item, where applicable, for review, or fails to satisfactorily show an ability to perform, the City can reject the response as inadequate.

## **16. PRICING**

Prices for all services shall be firm for the duration of this contract and shall be stated on the Proposal form. All prices must be written in ink or typewritten. Pricing on all transportation, freight, drayage and other charges are to be prepaid by the contractor and included in the response prices. If there are any additional charges of any kind, other than those mentioned above, specified or unspecified, Respondent MUST indicate the items required and attendant costs or forfeit the right to payment for such items. Where unit pricing and extended pricing differ, unit pricing prevails.

## **17. INTERPRETATIONS**

Any questions concerning the requirements or scope of work with regards to this solicitation for responses shall be directed to the designated individuals as outlined herein. Such interpretations, which may affect the eventual outcome of this solicitation for responses, shall be furnished in writing to all prospective Respondents via Addendum. No interpretation shall be considered binding unless provided in writing by the City in accordance with paragraph titled “**Addenda and Modifications.**”

## **18. ANTICIPATED TERM OF CONTRACT**

The anticipated term for the proposed contract is a 5 (five) year rate guarantee.

## 19. EVALUATION

The evaluation process shall be used to determine which services meet the criteria described in “**AWARD OF CONTRACT**” Section. All Responses are subject to tabulation by the City and recommendation to the City Council. Compliance with all response requirements, delivery and needs of the using department are considerations in evaluating responses. The City reserves the right to contact any Respondent, at any time, to clarify, verify or request information with regard to any response.

## 20. AWARD OF CONTRACT

In accordance with Section 252.043 of the Texas Local Government Code, the City seeks to contract with the best value proposer. In determining the best value proposer, the City may consider the following criteria:

- 1) the purchase price;
- 2) the experience and reputation of the Respondent and of the Respondent's goods or services;
- 3) the quality of the Respondent's goods or services;
- 4) the impact on the ability of the City to comply with laws and rules relating to contracting with historically underutilized businesses and nonprofit organizations employing persons with disabilities;
- 5) total long-term cost to the City to acquire the Respondent's goods or services; and
- 6) any other relevant criteria specifically listed in the Request for Responses.

**Respondents must provide sufficient information to allow the City to evaluate Proposers based on criteria above and the weighted selection criteria included in “Selection Criteria” Section.** To demonstrate qualifications to perform the Work, each Respondent must include with its submission written evidence, such as financial data, previous experience, present commitments and other such data that meets the best value considerations outlined in section 252.043 of the Texas Local Government Code. Each Proposal must contain evidence of Respondent's qualification to do business in the state of Texas or covenant to obtain such qualification prior to award of the contract.

The City reserves the right to accept any item or group of items on this response, unless the Respondent qualifies his/her response by specific limitations.

## 21. SELECTION PROCESS

Respondents should prepare a sealed proposal responsive to all information requested in this RFP.

The City will use a selection committee to evaluate the proposals. The City will select the response that submits the proposal that offers the best value for the Owner based on the criteria in this request and its ranking evaluation. The response received will be part of the selection process utilized by Owner. Owner reserves the right to and may contact Respondents with questions or clarifications relating to that Respondent's response to this RFP.

The Owner's selection committee will rank the Respondents and will notify each of the rankings within 45 days of proposal opening. The Owner will then negotiate with the highest ranked Respondent as allowed by statute. The set of Contract Documents, including the forms for the Contract and the Technical Specifications, are included with this RFP for Respondent evaluation prior to submission of a Proposal. If a contract cannot be successfully negotiated with the highest

ranked Respondent, in the opinion of Owner, negotiations will be terminated and Owner will proceed to negotiate with the next highest ranked Respondent in the order of the selection ranking until a mutually agreed contract can be negotiated or all proposals are rejected.

## **22. SELECTION CRITERIA**

The selection criteria used to evaluate the RFP responses will include, but not be limited to, the following (items listed below are not listed in order of importance):

1. Pricing and Rate Guarantees (weighted at 40%)
2. Proposed Terms and Plan Designs / 3rd party integration with Tyler Technologies (weighted at 40%)
3. Additional / Value Add Services (weighted at 10%)
4. References and Qualifications / Adherence to the RFP (weighted at 10%).

<b>SELECTION CRITERIA</b>	<b>WEIGHTED VALUE</b>
Pricing and Rate Guarantees	40%
Proposed Terms and Plan Designs / 3rd party integration Tyler	40%
Additional / Value Add Services	10%
References and Qualifications ? Adherence to the RFP	10%
<b>Total</b>	<b>100%</b>

Respondents shall include with the proposal all information and qualifications to allow the City's selection committee to evaluate the proposal in accordance with this section and the evaluation criteria listed here. The City reserves the right to request additional post-proposal information from any or all Respondents to assist in evaluating the proposal based on the selection criteria. The Owner reserves the right to reject any and all proposals. The Owner reserves the right to waive any and all irregularities in proposals.

## **23. RIGHT TO REJECT/ AWARD**

The City reserves the right to reject any or all Responses, to waive any or all formalities or technicalities, and to make such awards of contract to the Respondent who provides the best value to the City.

## **24. CLARIFICATION OF REQUIREMENTS AND QUESTIONS**

All requests for additional information or clarification concerning this response must be submitted **in writing** using the eProcurement site at <https://www.bidnetdirect.com/texas/city-of-victoria> or can be emailed to the Staff Contact Person on or before **12:00 PM CST, JULY 7, 2026**. Questions received after the stated deadline will not be answered. Questions submitted and the City's responses will be posted with this solicitation as addenda.

## **25. RESTRICTIONS ON COMMUNICATION**

Respondent(s) are prohibited from communicating with: 1) the City of Victoria City Council Members and City staff regarding the RFP or proposals from the time the RFP has been released until the contract is posted as a City Council agenda item; and 2) City employees from the time the RFP has been released until the contract is awarded. These restrictions extend to “thank you” letters, phone calls, emails and any contact that results in the direct or indirect discussion of the RFP or proposal submitted by Respondent. Violation of this provision by Respondent or its agent may lead to disqualification of Respondent’s proposal from consideration.

Exceptions to the restrictions on communication with City employees include:

- A. Respondents may ask verbal questions concerning this RFP at the Pre-Submittal Conference or submit clarification requests pursuant to **“ADDENDA AND MODIFICATIONS”** Section.
- B. Staff Contact located in the **“STAFF CONTACT”** section.

## **26. ADDENDA AND MODIFICATIONS**

Any changes, additions, or clarifications to the RFP are made by amendments (addenda) and will be posted on the Public Purchase website. Any respondent in doubt as to the true meaning of any part of the RFP or other documents may request an interpretation from the Staff Contact Person. At the request of the Respondent, or in the event the Staff Contact Person deems the interpretation to be substantive, the interpretation will be made by written addendum issued by the Procurement Manager. Such addendum will be attached to the original RFP in the Public Purchase file and will become part of the RFP package having the same binding effect as provisions of the original RFP. It shall be the Respondent(s) responsibility to ensure that they have received all Addenda with respect to this project. Furthermore, Respondents are advised that they must recognize, comply with, and attach a signed copy of each Addendum which shall be made part of their submittal. Respondent(s) signature on Addenda shall be interpreted as the respondent’s recognition and compliance to official changes as outlined by the City and as such are made part of the original RFP documents. Failure of any Respondent to receive any such addendum or interpretation shall not relieve such Respondent from its terms and requirements. Addendums are available online at <https://www.bidnetdirect.com/texas/city-of-victoria>. No verbal explanations or interpretations will be binding. The City does not assume responsibility for the receipt of any addendum sent to Respondents.

## **27. INVITATION FOR RESPONSES PREPARATION COSTS**

Issuance of this RFP does not commit the City, in any way, to pay any costs incurred in the preparation and submission of a response. All costs related to the preparation and submission of this RFP shall be borne by the Respondent.

## **28. EQUAL EMPLOYMENT OPPORTUNITY**

Respondent agrees that it will not discriminate in hiring, promotion, treatment, or other terms and conditions of employment based on race, sex, national origin, age, disability, or in any way violate Title VII of 1964 Civil Rights Act and amendments, except as permitted by said laws.

## **29. INDEPENDENT CONTRACTOR**

It is expressly understood and agreed by both parties hereto that the City is contracting with the successful Respondent as independent contractor. The parties hereto understand and agree that the City shall not be liable for any claims which may be asserted by any third party occurring in connection with the services to be performed by the successful Respondent under this contract and that the successful Respondent has no authority to bind the City.

## **30. INSURANCE**

Required Insurance Coverage. Any of the coverage set forth below may be waived by the City of Victoria in its sole discretion, but any such waiver must be signed by an authorized representative of the City of Victoria. The contracted Respondent will be required to maintain, at all times during performance of the Contract, the insurance detailed in the Insurance Rider attached as Exhibit A .

## **31. WARRANTIES**

Respondents shall furnish all data pertinent to warranties or guarantees which may apply to items in the response.

The Respondent shall warrant that any equipment furnished or work performed shall be free from defects in design, materials, workmanship, and will give successful service under the specified operating conditions. Furthermore, the Respondent agrees, upon notice from the City, to make good all defects in design, materials, or performance developing in the materials or equipment under its intended use for at least twelve (12) months from the date of installation and initial operation, or the manufacturer's warranty whichever is greater length of time.

In the event that the equipment must be returned to the factory under warranty, the Respondent shall be responsible for delivery charges both to and from the factory.

## **32. INDEMNIFICATION CLAUSE**

**TO THE FULLEST EXTENT PERMITTED BY LAW, THE RESPONDENT SHALL INDEMNIFY, DEFEND AND HOLD HARMLESS THE CITY OF VICTORIA AND EACH COUNCIL MEMBER, OFFICER, EMPLOYEE OR AGENT THEREOF (THE CITY OF VICTORIA AND ANY SUCH PERSON BEING HEREIN CALLED AN "INDEMNIFIED PARTY"), FOR, FROM AND AGAINST ANY AND ALL LOSSES, CLAIMS, DAMAGES, LIABILITIES, COSTS AND EXPENSES (INCLUDING, BUT NOT LIMITED TO, REASONABLE ATTORNEYS' FEES AND COURT COSTS) TO WHICH ANY SUCH INDEMNIFIED PARTY MAY BECOME SUBJECT, UNDER ANY THEORY OF LIABILITY WHATSOEVER ("CLAIMS"), INsofar AS SUCH CLAIMS (OR ACTIONS IN RESPECT THEREOF) RELATE TO, ARISE OUT OF, OR ARE CAUSED BY THE GOODS OR SERVICES PROVIDED BY THE RESPONDENT, ITS OFFICERS, EMPLOYEES, AGENTS, OR ANY TIER OF SUBCONTRACTOR IN THE PERFORMANCE OF THIS AGREEMENT.**

### **33. RESPONDENT'S EMPLOYEES**

Neither the Respondent nor his/her employees engaged in fulfilling the terms and conditions of any awarded contract shall be employees of the City. The method and manner of performance of such undertakings shall be under the exclusive control of the Respondent on contract. The City shall have the right of inspection of said undertakings at any time.

### **34. VERBAL THREATS**

Any threats made to any employee of the City, be it verbal or written, to discontinue the providing of item/material/services for whatever reason or reasons shall be considered a breach of contract and the City will immediately sever the contract with the vendor.

### **35. CONFIDENTIAL INFORMATION**

A. Any information deemed to be confidential or proprietary by the respondent should be clearly annotated on the pages where confidential or proprietary information is contained. The City cannot guarantee that it will not be required to disclose all or part of any public record under Texas Public Information Act, since information deemed to be confidential or proprietary by the responder may not be confidential or proprietary under Texas Law, or pursuant to a Court order. Pursuant to SB 943, the City must disclose certain contracting information and the law presumes that most contracting information is public. Certain types of contracting information must generally be released under the Public Information Act: overall price; price and description of items or services to be delivered; delivery and service deadlines; remedies for breach of contract; identity of the parties to the Contract; execution and effective dates; and information connected to a vendor or contractor's performance on the contract. Additionally, information regarding performance under the Contract, including breaches of the Contract, Contract variances, amendments, liquidated damages, and other penalties for non-performance, must generally be released under the Public Information Act.

B. The requirements of Subchapter J, Chapter 552, Government Code, may apply to this RFP and the contractor or vendor agrees that the Contract can be terminated if the contractor or vendor knowingly or intentionally fails to comply with a requirement of that subchapter.

### **36. JURISDICTION**

Contract(s) executed as part of this solicitation shall be subject to and governed under the laws of the State of Texas. Any and all obligations and payments are due and performable and payable in Victoria County, Texas.

### **37. VENUE**

The parties agree that exclusive venue for purposes of any and all lawsuits, cause of action, arbitration, or any other dispute(s) shall be in Victoria County, Texas.

### **38. CONFLICT OF INTEREST**

Chapter 176 of the Texas Local Government Code requires that any vendor or person considering doing business with a local government entity must disclose in the Questionnaire Form CIQ, the

vendor or person's affiliation or business relationship that might cause a conflict of interest with a local government entity. This questionnaire must be filed, by law, with the City no later than the

7th business day after the date the person becomes aware of facts that require the statement be filed. See Section 176.006, Local Government Code. A person commits an offense if the person violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor. For more information or to obtain the Questionnaire CIQ go to the Texas Ethics Commission web page at [www.ethics.state.tx.us/forms/CIQ.pdf](http://www.ethics.state.tx.us/forms/CIQ.pdf).

IF YOU HAVE ANY QUESTIONS ABOUT COMPLIANCE, PLEASE CONSULT YOUR OWN LEGAL COUNSEL. COMPLIANCE IS THE INDIVIDUAL RESPONSIBILITY OF EACH PERSON OR AGENT OF A PERSON WHO IS SUBJECT TO THE FILING REQUIREMENT. AN OFFENSE UNDER CHAPTER 176 IS A MISDEMEANOR.

### **39. CERTIFICATE OF INTERESTED PARTIES**

Pursuant to Section 2252.908, Texas Government Code, as amended and formal rules released by the Texas Ethics Commission (TEC), all contracts with private business entities requiring approval by the City of Victoria City Council, will require the on-line completion of Form 1295 "Certificate of Interested Parties." Form 1295 is also required for any and all contract amendments, extensions or renewals. Contractors are required to complete and file electronically with the Texas Ethics Commission using the online filing application.

Please visit the State of Texas Ethics Commission website, [https://www.ethics.state.tx.us/whatsnew/elf\\_info\\_form1295.htm](https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm) and <https://www.ethics.state.tx.us/tec/1295-Info.htm> for more information.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLIANCE, PLEASE CONSULT YOUR OWN LEGAL COUNSEL. COMPLIANCE IS THE INDIVIDUAL RESPONSIBILITY OF EACH PERSON OR AGENT OF A PERSON WHO IS SUBJECT TO THE FILING REQUIREMENT.

### **40. CONFIDENTIALITY OF INFORMATION AND SECURITY**

Should the successful respondent be awarded a contract and become the holder of, and have access to, confidential information, (in the process of fulfilling its responsibilities in connection with the contract), the successful respondent agrees that it shall keep such information confidential and will comply fully with the laws and regulations of the State of Texas, ordinances and regulations of the City of Victoria, and any applicable federal laws and regulations relating to confidentiality.

### **41. SUBSTITUTIONS/CANCELLATIONS OF RESPONSES**

No substitutions or cancellations are permitted without approval of the City.



## **42. ADDITIONAL REPRESENTATION**

A Respondent submitting a response to this RFP must submit a verified statement (Attachment C) that it does not boycott Israel and will not boycott Israel during the term of the Agreement as described in Chapter 2270 of the Texas Government Code as amended. Failure to comply with this requirement is grounds for disqualifications; however, the City reserves the right to contact Respondent who fails to comply initially to correct the omission or to confirm the Respondent's policy.

## **43. AGREEMENT**

The successful Respondent shall enter into a Contract with the City.

**PART II**  
**RESPONSE FORM A - PROPOSAL SIGNATURE PAGE**

<b>SUBMIT TO:</b> The City of Victoria Procurement Manager Bid Net Direct – Texas Purchasing Group <a href="https://www.bidnetdirect.com/texas/city-of-victoria">https://www.bidnetdirect.com/texas/city-of-victoria</a>		<h1 style="margin: 0;">REQUEST FOR PROPOSAL</h1> <h2 style="margin: 0;">(RFP)</h2>	
<b>Title:</b>	LIFE AND DISABILITY INSURANCE		
<b>Number:</b>	RFP-TA-7232026-LDI	<b>Closing Date &amp; Time:</b>	JULY 23, 2026 AT 10:00 AM CST
<b>NAME OF PARTNERSHIP, CORPORATION OR INDIVIDUAL</b>		<b>TAXPAYER IDENTIFICATION NUMBER</b>	
<b>MAILING ADDRESS</b>		<b>NO RESPONSE: If not submitting a response, state reason below and return one copy of this form</b>	
<b>CITY, STATE ZIP</b>			
<b>PHONE</b>		<b>EMAIL</b>	
<b>FAX</b>		<b>WEB ADDRESS</b>	
		<b>DELIVERY:</b> Calendar days after receipt of Purchase Order: <div style="text-align: center;">_____ days (ARO)</div>	
<b>RESPONSES ARE FIRM FOR ACCEPTANCE FOR 120 DAYS</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER		<b>PAYMENT TERMS</b>  <div style="text-align: center;">_____ % / Net _____</div>	
I certify that this response is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a response for the same materials, supplies, or equipment and is in all respects fair and without collusion or fraud. I agree to all conditions of this response and certify that I am authorized to sign this response for the Respondent. In submitting a response to the City, the Respondent offers and agrees that if the response is accepted, the Respondent will convey, sell, assign or transfer to the City all rights, titles and interest in and to all causes to action it may now or hereafter acquire under the Anti-trust laws of the United States and the State of Texas for price fixing relating to the particular commodities or services purchased or acquired by the City. At the City's discretion, such assignment shall be made and become effective at the time the City tenders final payment to the Respondent.			
<b>AUTHORIZED SIGNATURE</b>		<b>DATE</b>	<b>PRINTED NAME/TITLE</b>
<b>Please initial by all that apply. I acknowledge receipt of the following addendum.</b>			
Addendum #1 _____ Addendum #2 _____ Addendum #3 _____ Addendum #4 _____			

**Please Note:**

- This page must be completed and returned with your response.
- Responses received after the above closing date and time will not be accepted.

## RESPONSE FORM B – PROPOSAL FORM

To: City of Victoria, Texas  
702 N. Main Street, Suite 132  
Victoria, Texas 77901

Project: \_\_\_\_\_

RFP No.: \_\_\_\_\_

Project No.: \_\_\_\_\_

Respondent: \_\_\_\_\_

(Print or type full name of proprietorship, partnership, corporation, or joint venture)

### 1.1 Proposal

**A. Total Proposal Price:** The undersigned Respondent proposes and agrees, if this Proposal is accepted, to enter into an Agreement with City of Victoria, Texas, in the form included in the Proposal Documents to provide goods/services as specified or indicated in the Proposal Documents for the Contract Amount indicated in this Proposal or as modified by amendment.

**B. Period for Proposal Acceptance:** Respondent accepts all of the terms and conditions of the Request for Proposals and Instructions to Respondents. This offer shall remain open to acceptance and is irrevocable for 120 days after Proposal Date (opening). That period may be extended by mutual written agreement of City and Respondent.

**C. Addenda:** Respondent hereby acknowledges it has received, examined and carefully studied all Addenda and all Addenda have been considered and all related costs are included in the Total Proposal Price.

### 2.1 RESPONDENT REPRESENTATIONS

**A.** Respondent is familiar with and is satisfied as to all federal, state and local laws and regulations that may affect cost, progress, performance and furnishing of the goods/services.

**B.** The Proposal Documents are generally sufficient to indicate and convey understanding of all terms and conditions for performing and furnishing the goods/services for which this Proposal is submitted.

**C. Laws to be Observed:** In the performance of the Contract, the Contractor must comply with all applicable federal, state, and local laws, ordinances and regulations, including but not limited to laws concerned with labor, safety, minimum wages, and the environment. The Contractor will make himself familiar with and shall at all times observe and comply with all federal, state, and local laws, ordinances and regulations which in any manner affect the conduct of the work, and SHALL INDEMNIFY AND SAVE HARMLESS THE CITY OF VICTORIA, AND ITS REPRESENTATIVES AGAINST ANY CLAIM ARISING FROM VIOLATION OF ANY SUCH LAW, ORDINANCE OR REGULATION BY HIMSELF OR BY HIS AGENT OR BY HIS EMPLOYEES.

- D. Review by City: The City and authorized representatives, agents and employees of the City shall at all times have access to and be permitted to observe and review all work, materials, equipment, payrolls, personnel records, employment conditions, material invoices, books and accounting records, subcontracts, purchase orders, and all other relevant data, documents and records pertaining to this Contract.
- E. Respondent will submit written evidence of its authority to do business in the state where the Project is located with its Proposal.
- F. Respondent further represents that this Proposal is genuine and not made in the interest of or on behalf of any undisclosed individual or entity and is not submitted in conformity with any agreement or rules of any group, association, organization or corporation; Respondent has not directly or indirectly induced or solicited any other Respondent to submit a false or sham Proposal; Respondent has not solicited or induced any individual or entity to refrain from submitting a Proposal; and Respondent has not sought by collusion to obtain for itself any advantage over any other Respondent or over the City.

### **3.1 EVALUATION CRITERIA**

- 1. Pricing and Rate Guarantees (weighted at 40%).
- 2. Proposed Terms and Plan Designs / 3rd party integration with Tyler Technologies (weighted at 40%).
- 3. Additional / Value Add Services (weighted at 10%).
- 4. References and Qualifications / Adherence to the RFP (weighted at 10%).

#### 4.1 SIGNATURES:

By signing this Document, I agree that I have received and reviewed all Proposal Documents, Requirements/Specifications, and Addenda and considered all costs associated with the Proposal Documents, Requirements/Specifications, and Addenda in calculating the Total Proposal Price.

Respondent: \_\_\_\_\_

(Print or type full name of your proprietorship, partnership, corporation or joint venture\*)

\*If Proposal is a joint venture, add additional Proposal Form signature sheets for each member of the joint venture.

By: \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Doing Business as: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

## 5.1 CERTIFICATION OF PROPOSAL

**The undersigned affirms that they are duly authorized to execute this Proposal, that this Proposal has not been prepared in collusion with any other Respondent, and that the contents of this Proposal have not been communicated to any other Respondent prior to the official opening of this Proposal. Additionally, the undersigned affirms that the Respondent is willing to sign the attached Agreement (if applicable). Further, Respondent certifies that the only person or parties interested in this offer as principals are those named herein. Respondent has not directly or indirectly entered into any agreement, participated in any collusion, or otherwise taken any action in restraint of free competitive proposing.**

Signed By:

Title:

---

Typed Name:

Company Name:

---

Phone No.:

Fax No.:

---

Email:

---

Proposal Address:

P.O. Box or Street

City, State Zip

---

Order Address:

P.O. Box or Street

City, State Zip

---

Remit to Address:

P.O. Box or Street

City, State Zip

---

Federal Tax ID No.:

---

Date:

---

# ATTACHMENT A - SCOPE OF WORK

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

## Basic Life and Accidental Death & Dismemberment Insurance

City of Victoria provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through The Hartford, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

## Employer Paid Benefit

Your Basic Life and AD&D insurance benefit is 1 times your base annual earnings, up to \$100,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

## Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the The Hartford insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact or your own legal counsel with any questions.

## Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	1, 2, or 3 times base annual earnings rounded to the next \$1,000
WHO PAYS	Employee
MAXIMUM BENEFIT	\$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes, for coverage amounts higher than the Guarantee Issue amount of \$300,000; requests for coverage increases; reinstatements; and all late applications (applying 31 days after becoming eligible).
VOLUNTARY SPOUSE LIFE/AD&D	
COVERAGE AMOUNT	\$5,000 increments, not to exceed 100% of the employee elected and approved voluntary amount
WHO PAYS	Employee
MAXIMUM BENEFIT	\$250,000 and cannot exceed employee amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes, for coverage amounts higher than the Guarantee Issue amount of \$50,000; requests for coverage increases; reinstatements; and all late applications (applying 31 days after becoming eligible).
VOLUNTARY CHILD LIFE/AD&D	
COVERAGE AMOUNT	Increments of \$5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	\$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

VOLUNTARY LIFE/AD&D INSURANCE			
RATES/\$1,000 (MONTHLY) SPOUSE PREMIUM IS BASED ON EMPLOYEE'S AGE			
AGE (AS OF JANUARY 1, 2026)	EMPLOYEE RATE*	AGE (AS OF JANUARY 1, 2026)	SPOUSE RATE*
Any age	\$0.220*	<30	\$0.086*
		30-34	\$0.100*
		35-39	\$0.111*
		40-44	\$0.133*
		45-49	\$0.198*
		50-54	\$0.297*
		55-59	\$0.460*
		60-64	\$0.680*
		65-69	\$1.290*
		70-74	\$2.080*
		75+	\$4.171*

\*Includes a monthly AD&D rate of \$0.02 per \$1,000 of AD&D benefit.

\*Includes a monthly AD&D rate of \$0.02 per \$1,000 of AD&D benefit for your spouse.

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES – \$1,000
\$0.230*

\*Includes a monthly AD&D rate of \$0.03 per \$1,000 of AD&D benefit for your child.





## Income Protection

You and your loved ones depend on your regular income. That's why City of Victoria offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

### Voluntary Short-Term Disability (STD) Insurance

STD benefits are available for purchase on a voluntary basis. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Unless you are newly eligible, you must provide Evidence of Insurability (EOI) to enroll into this coverage. Only accidents or injuries that occur off the job are covered. Certain exclusions, along with pre-existing condition limitations, may apply. Evidence of Insurability (EOI) is required for those who elect to enroll outside of their initial enrollment period. See your plan documents or for details.

WEEKLY MAXIMUM BENEFIT	\$1,000
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	13 weeks

VOLUNTARY STD INSURANCE
COMPOSITE RATE
\$0.225 per \$10 of covered benefit

### Voluntary Long-Term Disability (LTD) Insurance

LTD benefits are available for purchase on a voluntary basis. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Unless you are newly eligible, you must provide Evidence of Insurability (EOI) to enroll into this coverage. The LTD plan is 24-hour coverage for both on and off the job accidents or injuries. Certain exclusions, along with pre-existing condition limitations, may apply. Evidence of Insurability (EOI) is required for those who elect to enroll outside of their initial enrollment period. See your plan documents or for details.

MONTHLY MAXIMUM BENEFIT	\$5,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

VOLUNTARY LTD INSURANCE	
AGE (AS OF JANUARY 1, 2026)	
AGE RANGE	LTD
<30	\$0.164
30-34	\$0.227
35-39	\$0.308
40-44	\$0.431
45-49	\$0.785
50-54	\$1.058
55-59	\$1.464
60-64	\$1.297
65-69	\$0.776
70-99	\$0.585

## **ATTACHMENT A - CORE LINE COVERAGE**

- We noticed the provided reports are for 2026. As we require the last 5 years data, please provide us the experience reports for all lines for the last 5 years.

Core lines have only been inforce since 1/1/2024. Provided experience starts 1/1/2024 for the LTD and STD. We don't provide Life experience for cases under 1000 lives.

- Claims listings for all lines for the last 5 years to include the claimant's information, start/end date, open/closed status, benefits, etc.

Core lines have only been inforce since 1/1/2024. Provided experience starts 1/1/2024 for the LTD and STD. We don't provide Life experience for cases under 1000 lives.

- Rate history for all lines from 2022 to 2025.

Confirmed there haven't been any rate changes in the core lines since inception.

- We received the premium summary. Please provide 3 formal invoices for all lines from Jan. 26 to Apr. 26.

Attached are the invoices.



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 688164770506  
Customer #: 015767010004  
Policy #: GRH 891798

**BILLING PERIOD: 02/01/2026-02/28/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - STD</b>					
Policy #: <b>GRH 891798</b>					
<b>SHORT TERM DISABILITY</b>	<b>225</b>	<b>144,219.87 X</b>	0.2250	PER \$10 WKLY BENEFIT	<b>\$3,244.85</b>
<b>Experience Group Subtotal =</b>					<b>\$3,244.85</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 084195380467  
Customer #: 015767010006  
Policy #: OGL 891798

**BILLING PERIOD: 02/01/2026-02/28/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: CITY VICTORIA-SP LIFE/SUP ADD					
Policy #: OGL 891798					
<b>SUPPLEMENTAL LIFE</b>	<b>233</b>	<b>34,170,000.00 X</b>	0.2000	PER \$1000	<b>\$6,834.00</b>
SUPP DEPENDENT LIFE < 25	0	0.00 X	0.0660	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 25 - 29	2	65,000.00 X	0.0660	PER \$1000 SPOUSE	\$4.29
SUPP DEPENDENT LIFE 30 - 34	4	165,000.00 X	0.0800	PER \$1000 SPOUSE	\$13.20
SUPP DEPENDENT LIFE 35 - 39	6	245,000.00 X	0.0910	PER \$1000 SPOUSE	\$22.30
SUPP DEPENDENT LIFE 40 - 44	11	490,000.00 X	0.1130	PER \$1000 SPOUSE	\$55.37
SUPP DEPENDENT LIFE 45 - 49	3	110,000.00 X	0.1780	PER \$1000 SPOUSE	\$19.58
SUPP DEPENDENT LIFE 50 - 54	10	390,000.00 X	0.2770	PER \$1000 SPOUSE	\$108.04
SUPP DEPENDENT LIFE 55 - 59	8	325,000.00 X	0.4400	PER \$1000 SPOUSE	\$143.00
SUPP DEPENDENT LIFE 60 - 64	6	235,000.00 X	0.6600	PER \$1000 SPOUSE	\$155.10
SUPP DEPENDENT LIFE 65 - 69	2	75,000.00 X	1.2700	PER \$1000 SPOUSE	\$95.25
SUPP DEPENDENT LIFE 70 - 74	0	0.00 X	2.0600	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 75 - AND OVER	0	0.00 X	4.1510	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE	105	1,030,000.00 X	0.0200	PER \$1000 CHILD	\$20.60
<b>TOTAL SUPP DEPENDENT LIFE</b>	<b>157</b>	<b>3,130,000.00</b>			<b>\$636.73</b>
<b>SUPPLEMENTAL AD/D</b>	<b>233</b>	<b>34,318,000.00 X</b>	0.0200	PER \$1000	<b>\$686.36</b>
SUPP DEPENDENT AD/D	52	2,100,000.00 X	0.0200	PER \$1000 SPOUSE ADD	\$42.00
SUPP DEPENDENT AD/D	105	1,030,000.00 X	0.0300	PER \$1000 CHILD ADD	\$30.90
<b>TOTAL SUPP DEPENDENT AD/D</b>	<b>157</b>	<b>3,130,000.00</b>			<b>\$72.90</b>
<b>Experience Group Subtotal =</b>					<b>\$8,229.99</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 743598287865  
Customer #: 015767010003  
Policy #: OGL 891798

**BILLING PERIOD: 03/01/2026-03/31/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSURED	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA-LIFE/ADD</b>					
Policy #: <b>0GL 891798</b>					
LIFE	588	34,349,000.00 X	0.0600	PER \$1000	\$2,060.94
AD/D	588	34,349,000.00 X	0.0150	PER \$1000	\$516.55
Experience Group Subtotal =					\$2,577.49



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 177727922118  
Customer #: 015767010005  
Policy #: GLT 891798

**BILLING PERIOD: 03/01/2026-03/31/2026**

**ACCOUNT DETAIL - CURRENT PREMIUM**

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - LTD</b>					
Policy #: <b>GLT 891798</b>					
LONG TERM DISABILITY < 25	12	33,477.09 X	0.1640	PER \$100 COV BENEFIT	\$54.89
LONG TERM DISABILITY 25 - 29	37	103,312.10 X	0.1640	PER \$100 COV BENEFIT	\$169.40
LONG TERM DISABILITY 30 - 34	24	68,305.96 X	0.2270	PER \$100 COV BENEFIT	\$155.04
LONG TERM DISABILITY 35 - 39	35	120,650.28 X	0.3080	PER \$100 COV BENEFIT	\$371.60
LONG TERM DISABILITY 40 - 44	45	160,381.34 X	0.4310	PER \$100 COV BENEFIT	\$691.24
LONG TERM DISABILITY 45 - 49	25	80,247.97 X	0.7850	PER \$100 COV BENEFIT	\$629.95
LONG TERM DISABILITY 50 - 54	24	75,841.53 X	1.0580	PER \$100 COV BENEFIT	\$802.41
LONG TERM DISABILITY 55 - 59	19	60,432.60 X	1.4640	PER \$100 COV BENEFIT	\$884.72
LONG TERM DISABILITY 60 - 64	17	46,852.51 X	1.2970	PER \$100 COV BENEFIT	\$607.68
LONG TERM DISABILITY 65 - 69	7	17,833.55 X	0.7760	PER \$100 COV BENEFIT	\$138.39
LONG TERM DISABILITY 70 - 74	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
LONG TERM DISABILITY 75 - AND OVER	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
<b>TOTAL LONG TERM DISABILITY</b>	<b>245</b>	<b>767,334.93</b>			<b>\$4,505.32</b>
<b>Experience Group Subtotal =</b>					<b>\$4,505.32</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 688168168126  
Customer #: 015767010004  
Policy #: GRH 891798

**BILLING PERIOD: 03/01/2026-03/31/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - STD</b>					
Policy #: <b>GRH 891798</b>					
<b>SHORT TERM DISABILITY</b>	<b>222</b>	<b>142,562.30 X</b>	0.2250	PER \$10 WKLY BENEFIT	<b>\$3,207.56</b>
<b>Experience Group Subtotal =</b>					<b>\$3,207.56</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 084197980328  
Customer #: 015767010006  
Policy #: 0GL 891798

**BILLING PERIOD: 03/01/2026-03/31/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY VICTORIA-SP LIFE/SUP ADD</b>					
Policy #: <b>0GL 891798</b>					
<b>SUPPLEMENTAL LIFE</b>	<b>233</b>	<b>34,170,000.00 X</b>	0.2000	PER \$1000	<b>\$6,834.00</b>
SUPP DEPENDENT LIFE < 25	0	0.00 X	0.0660	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 25 - 29	2	65,000.00 X	0.0660	PER \$1000 SPOUSE	\$4.29
SUPP DEPENDENT LIFE 30 - 34	4	165,000.00 X	0.0800	PER \$1000 SPOUSE	\$13.20
SUPP DEPENDENT LIFE 35 - 39	6	245,000.00 X	0.0910	PER \$1000 SPOUSE	\$22.30
SUPP DEPENDENT LIFE 40 - 44	11	490,000.00 X	0.1130	PER \$1000 SPOUSE	\$55.37
SUPP DEPENDENT LIFE 45 - 49	3	110,000.00 X	0.1780	PER \$1000 SPOUSE	\$19.58
SUPP DEPENDENT LIFE 50 - 54	10	390,000.00 X	0.2770	PER \$1000 SPOUSE	\$108.04
SUPP DEPENDENT LIFE 55 - 59	8	325,000.00 X	0.4400	PER \$1000 SPOUSE	\$143.00
SUPP DEPENDENT LIFE 60 - 64	6	235,000.00 X	0.6600	PER \$1000 SPOUSE	\$155.10
SUPP DEPENDENT LIFE 65 - 69	2	75,000.00 X	1.2700	PER \$1000 SPOUSE	\$95.25
SUPP DEPENDENT LIFE 70 - 74	0	0.00 X	2.0600	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 75 - AND OVER	0	0.00 X	4.1510	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE	105	1,030,000.00 X	0.0200	PER \$1000 CHILD	\$20.60
<b>TOTAL SUPP DEPENDENT LIFE</b>	<b>157</b>	<b>3,130,000.00</b>			<b>\$636.73</b>
<b>SUPPLEMENTAL AD/D</b>	<b>233</b>	<b>34,318,000.00 X</b>	0.0200	PER \$1000	<b>\$686.36</b>
SUPP DEPENDENT AD/D	52	2,100,000.00 X	0.0200	PER \$1000 SPOUSE ADD	\$42.00
SUPP DEPENDENT AD/D	105	1,030,000.00 X	0.0300	PER \$1000 CHILD ADD	\$30.90
<b>TOTAL SUPP DEPENDENT AD/D</b>	<b>157</b>	<b>3,130,000.00</b>			<b>\$72.90</b>
<b>Experience Group Subtotal =</b>					<b>\$8,229.99</b>





Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 177728996283  
Customer #: 015767010005  
Policy #: GLT 891798

**BILLING PERIOD: 04/01/2026-04/30/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - LTD</b>					
Policy #: <b>GLT 891798</b>					
LONG TERM DISABILITY < 25	12	33,477.09 X	0.1640	PER \$100 COV BENEFIT	\$54.89
LONG TERM DISABILITY 25 - 29	37	103,312.10 X	0.1640	PER \$100 COV BENEFIT	\$169.40
LONG TERM DISABILITY 30 - 34	24	68,305.96 X	0.2270	PER \$100 COV BENEFIT	\$155.04
LONG TERM DISABILITY 35 - 39	35	120,650.28 X	0.3080	PER \$100 COV BENEFIT	\$371.60
LONG TERM DISABILITY 40 - 44	45	160,381.34 X	0.4310	PER \$100 COV BENEFIT	\$691.24
LONG TERM DISABILITY 45 - 49	25	80,785.52 X	0.7850	PER \$100 COV BENEFIT	\$634.17
LONG TERM DISABILITY 50 - 54	24	75,841.53 X	1.0580	PER \$100 COV BENEFIT	\$802.41
LONG TERM DISABILITY 55 - 59	19	60,432.60 X	1.4640	PER \$100 COV BENEFIT	\$884.72
LONG TERM DISABILITY 60 - 64	17	46,852.51 X	1.2970	PER \$100 COV BENEFIT	\$607.68
LONG TERM DISABILITY 65 - 69	7	17,833.55 X	0.7760	PER \$100 COV BENEFIT	\$138.39
LONG TERM DISABILITY 70 - 74	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
LONG TERM DISABILITY 75 - AND OVER	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
<b>TOTAL LONG TERM DISABILITY</b>	<b>245</b>	<b>767,872.48</b>			<b>\$4,509.54</b>
<b>Experience Group Subtotal =</b>					<b>\$4,509.54</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 688169160308  
Customer #: 015767010004  
Policy #: GRH 891798

**BILLING PERIOD: 04/01/2026-04/30/2026**

**ACCOUNT DETAIL - CURRENT PREMIUM**

<i>Legend:</i> * - Personal Health Application Required	S - Spouse	C - Child	WAIVE - Premium Waiver Applied
PEND - Late Entrant PHA Required	<b>BOLD</b> - Employee Record Modified	YES - Active Spouse and/or Child Coverage	

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSURED	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - STD</b>					
Policy #: <b>GRH 891798</b>					
<b>SHORT TERM DISABILITY</b>	<b>224</b>	<b>144,025.10 X</b>	0.2250	PER \$10 WKLY BENEFIT	<b>\$3,240.48</b>
<b>Experience Group Subtotal =</b>					<b>\$3,240.48</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 084198949517  
Customer #: 015767010006  
Policy #: OGL 891798

**BILLING PERIOD: 04/01/2026-04/30/2026**

**ACCOUNT DETAIL - CURRENT PREMIUM**

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY VICTORIA-SP LIFE/SUP ADD</b>					
Policy #: <b>OGL 891798</b>					
<b>SUPPLEMENTAL LIFE</b>	<b>234</b>	<b>34,333,000.00 X</b>	0.2000	PER \$1000	<b>\$6,866.60</b>
SUPP DEPENDENT LIFE < 25	0	0.00 X	0.0660	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 25 - 29	3	115,000.00 X	0.0660	PER \$1000 SPOUSE	\$7.59
SUPP DEPENDENT LIFE 30 - 34	4	165,000.00 X	0.0800	PER \$1000 SPOUSE	\$13.20
SUPP DEPENDENT LIFE 35 - 39	6	245,000.00 X	0.0910	PER \$1000 SPOUSE	\$22.30
SUPP DEPENDENT LIFE 40 - 44	10	440,000.00 X	0.1130	PER \$1000 SPOUSE	\$49.72
SUPP DEPENDENT LIFE 45 - 49	3	110,000.00 X	0.1780	PER \$1000 SPOUSE	\$19.58
SUPP DEPENDENT LIFE 50 - 54	10	390,000.00 X	0.2770	PER \$1000 SPOUSE	\$108.04
SUPP DEPENDENT LIFE 55 - 59	8	325,000.00 X	0.4400	PER \$1000 SPOUSE	\$143.00
SUPP DEPENDENT LIFE 60 - 64	6	235,000.00 X	0.6600	PER \$1000 SPOUSE	\$155.10
SUPP DEPENDENT LIFE 65 - 69	2	75,000.00 X	1.2700	PER \$1000 SPOUSE	\$95.25
SUPP DEPENDENT LIFE 70 - 74	0	0.00 X	2.0600	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 75 - AND OVER	0	0.00 X	4.1510	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE	100	980,000.00 X	0.0200	PER \$1000 CHILD	\$19.60
<b>TOTAL SUPP DEPENDENT LIFE</b>	<b>152</b>	<b>3,080,000.00</b>			<b>\$633.38</b>
<b>SUPPLEMENTAL AD/D</b>	<b>234</b>	<b>34,481,000.00 X</b>	0.0200	PER \$1000	<b>\$689.62</b>
SUPP DEPENDENT AD/D	52	2,100,000.00 X	0.0200	PER \$1000 SPOUSE ADD	\$42.00
SUPP DEPENDENT AD/D	100	980,000.00 X	0.0300	PER \$1000 CHILD ADD	\$29.40
<b>TOTAL SUPP DEPENDENT AD/D</b>	<b>152</b>	<b>3,080,000.00</b>			<b>\$71.40</b>
<b>Experience Group Subtotal =</b>					<b>\$8,261.00</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 743590459116  
Customer #: 015767010003  
Policy #: OGL 891798

**BILLING PERIOD: 02/01/2026-02/28/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA-LIFE/ADD</b>					
Policy #: <b>OGL 891798</b>					
LIFE	589	34,382,000.00 X	0.0600	PER \$1000	<b>\$2,062.92</b>
AD/D	589	34,382,000.00 X	0.0150	PER \$1000	<b>\$517.05</b>
Experience Group Subtotal =					<b>\$2,579.97</b>

### EMPLOYEE DETAIL

Employee detail displays Benefit Amount or Covered Salary and Premium Due.

Experience Group Name: **CITY OF VICTORIA-LIFE/ADD**  
Policy #: **OGL 891798**



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 177729668214  
Customer #: 015767010005  
Policy #: GLT 891798

**BILLING PERIOD: 02/01/2026-02/28/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - LTD</b>					
Policy #: <b>GLT 891798</b>					
LONG TERM DISABILITY < 25	12	33,477.09 X	0.1640	PER \$100 COV BENEFIT	\$54.89
LONG TERM DISABILITY 25 - 29	38	105,286.02 X	0.1640	PER \$100 COV BENEFIT	\$172.64
LONG TERM DISABILITY 30 - 34	24	68,305.96 X	0.2270	PER \$100 COV BENEFIT	\$155.04
LONG TERM DISABILITY 35 - 39	35	120,650.28 X	0.3080	PER \$100 COV BENEFIT	\$371.60
LONG TERM DISABILITY 40 - 44	45	160,381.34 X	0.4310	PER \$100 COV BENEFIT	\$691.24
LONG TERM DISABILITY 45 - 49	25	80,247.97 X	0.7850	PER \$100 COV BENEFIT	\$629.95
LONG TERM DISABILITY 50 - 54	25	79,218.13 X	1.0580	PER \$100 COV BENEFIT	\$838.13
LONG TERM DISABILITY 55 - 59	19	60,432.60 X	1.4640	PER \$100 COV BENEFIT	\$884.72
LONG TERM DISABILITY 60 - 64	17	46,852.51 X	1.2970	PER \$100 COV BENEFIT	\$607.68
LONG TERM DISABILITY 65 - 69	7	17,833.55 X	0.7760	PER \$100 COV BENEFIT	\$138.39
LONG TERM DISABILITY 70 - 74	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
LONG TERM DISABILITY 75 - AND OVER	0	0.00 X	0.5850	PER \$100 COV BENEFIT	\$0.00
<b>TOTAL LONG TERM DISABILITY</b>	<b>247</b>	<b>772,685.45</b>			<b>\$4,544.28</b>
<b>Experience Group Subtotal =</b>					<b>\$4,544.28</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 743591268280  
Customer #: 015767010003  
Policy #: 0GL 891798

**BILLING PERIOD: 01/01/2026-01/31/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

*Legend:* \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA-LIFE/ADD</b>					
Policy #: <b>0GL 891798</b>					
LIFE	576	33,630,000.00 X	0.0600	PER \$1000	\$2,017.80
AD/D	576	33,630,000.00 X	0.0150	PER \$1000	\$505.75
Experience Group Subtotal =					\$2,523.55

### EMPLOYEE DETAIL

Employee detail displays Benefit Amount or Covered Salary and Premium Due.

Experience Group Name: **CITY OF VICTORIA-LIFE/ADD**  
Policy #: **0GL 891798**

INSURED NAME EMPLOYEE ID	LIFE (000)	AD/D BASIC (000)	TOTAL PREMIUM
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Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 688161249522  
Customer #: 015767010004  
Policy #: GRH 891798

**BILLING PERIOD: 01/01/2026-01/31/2026**

### ACCOUNT DETAIL - CURRENT PREMIUM

Legend: \* - Personal Health Application Required    S - Spouse    C - Child    WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required    **BOLD** - Employee Record Modified    YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: <b>CITY OF VICTORIA - STD</b>					
Policy #: <b>GRH 891798</b>					
<b>SHORT TERM DISABILITY</b>	<b>220</b>	<b>140,524.61 X</b>	0.2250	PER \$10 WKLY BENEFIT	<b>\$3,161.72</b>
<b>Experience Group Subtotal =</b>					<b>\$3,161.72</b>



Business Insurance  
Employee Benefits  
Auto  
Home

Invoice #: 084197729269  
Customer #: 015767010006  
Policy #: OGL 891798

**BILLING PERIOD: 01/01/2026-01/31/2026**

**ACCOUNT DETAIL - CURRENT PREMIUM**

Legend: \* - Personal Health Application Required S - Spouse C - Child WAIVE - Premium Waiver Applied  
PEND - Late Entrant PHA Required **BOLD** - Employee Record Modified YES - Active Spouse and/or Child Coverage

The # of Insureds and volume information below has been calculated using the enrollment/eligibility data received from your file feeds. This invoice reflects enrollment on record at The Hartford at the time the invoice generated; it does not guarantee, nor certify, employee coverage. Any retroactive changes will be included in a future billing statement.

**Eligibility for benefits is maintained by the Employer.**

COVERAGE	# OF INSUREDS	VOLUME	RATE	RATE DEFINITION	PREMIUM DUE
Experience Group Name: CITY VICTORIA-SP LIFE/SUP ADD					
Policy #: OGL 891798					
<b>SUPPLEMENTAL LIFE</b>	<b>232</b>	<b>33,984,000.00 X</b>	0.2000	PER \$1000	<b>\$6,796.80</b>
SUPP DEPENDENT LIFE < 25	0	0.00 X	0.0660	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 25 - 29	2	65,000.00 X	0.0660	PER \$1000 SPOUSE	\$4.29
SUPP DEPENDENT LIFE 30 - 34	4	165,000.00 X	0.0800	PER \$1000 SPOUSE	\$13.20
SUPP DEPENDENT LIFE 35 - 39	6	245,000.00 X	0.0910	PER \$1000 SPOUSE	\$22.30
SUPP DEPENDENT LIFE 40 - 44	11	490,000.00 X	0.1130	PER \$1000 SPOUSE	\$55.37
SUPP DEPENDENT LIFE 45 - 49	3	110,000.00 X	0.1780	PER \$1000 SPOUSE	\$19.58
SUPP DEPENDENT LIFE 50 - 54	10	390,000.00 X	0.2770	PER \$1000 SPOUSE	\$108.04
SUPP DEPENDENT LIFE 55 - 59	8	325,000.00 X	0.4400	PER \$1000 SPOUSE	\$143.00
SUPP DEPENDENT LIFE 60 - 64	6	235,000.00 X	0.6600	PER \$1000 SPOUSE	\$155.10
SUPP DEPENDENT LIFE 65 - 69	2	75,000.00 X	1.2700	PER \$1000 SPOUSE	\$95.25
SUPP DEPENDENT LIFE 70 - 74	0	0.00 X	2.0600	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE 75 - AND OVER	0	0.00 X	4.1510	PER \$1000 SPOUSE	\$0.00
SUPP DEPENDENT LIFE	106	1,040,000.00 X	0.0200	PER \$1000 CHILD	\$20.80
<b>TOTAL SUPP DEPENDENT LIFE</b>	<b>158</b>	<b>3,140,000.00</b>			<b>\$636.93</b>
<b>SUPPLEMENTAL AD/D</b>	<b>232</b>	<b>34,132,000.00 X</b>	0.0200	PER \$1000	<b>\$682.64</b>
SUPP DEPENDENT AD/D	52	2,100,000.00 X	0.0200	PER \$1000 SPOUSE ADD	\$42.00
SUPP DEPENDENT AD/D	106	1,040,000.00 X	0.0300	PER \$1000 CHILD ADD	\$31.20
<b>TOTAL SUPP DEPENDENT AD/D</b>	<b>158</b>	<b>3,140,000.00</b>			<b>\$73.20</b>
<b>Experience Group Subtotal =</b>					<b>\$8,189.57</b>



# BENEFIT PLAN



**Basic Term Life, Supplemental Dependent Life, Supplemental Term Life, Basic Accidental Death and Dismemberment, Supplemental Accidental Death and Dismemberment**

# BENEFIT PLAN



# YOUR BENEFIT PLAN



### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

#### **Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

#### **Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**Maryland**

**The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

## State Notices

**IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:** There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at <https://www.thehartford.com/>. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

**The Hartford**  
**Group Benefits Division, Customer Service**  
**P.O. Box 2999**  
**Hartford, CT 06104-2999**  
**1-800-523-2233**

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

### **Alaska:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

### **Arizona:**

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

### **Arkansas:**

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:  
Arkansas Insurance Department  
1 Commerce Way, Suite 102  
Little Rock, AR 72202
2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you

### **California:**

1. **NOTICE: READ YOUR CERTIFICATE CAREFULLY**  
You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

**Eligibility Determination:** *How will We determine Your eligibility for benefits?*

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

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

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

3. **For Your Questions and Complaints:**

State of California Insurance Department  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
**Toll Free:** 1(800) 927-HELP  
**TDD Number:** 1(800) 482-4833  
**Web Address:** [www.insurance.ca.gov](http://www.insurance.ca.gov)

**Colorado:**

1. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
2. The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

**Complications of Pregnancy** means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:

- 1) acute nephritis or nephrosis;
- 2) cardiac decompensation;
- 3) missed abortion; and
- 4) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include:

- 1) pre-eclampsia;
- 2) placenta previa;
- 3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
- 4) termination of ectopic pregnancy;
- 5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
- 6) non-elective Cesarean section; and
- 7) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:

- 1) elective Cesarean section;
  - 2) false labor, occasional spotting, or morning sickness;
  - 3) hyperemesis gravidarum; or
  - 4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.
3. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

4. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

**Florida:**

1. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

**Georgia:**

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

**Idaho:**

1. **For Your Questions and Complaints:**  
Idaho Department of Insurance  
Consumer Affairs  
700 W State Street, 3rd Floor  
PO Box 83720  
Boise, ID 83720-0043  
**Toll Free:** 1-800-721-3272  
**Web Address:** [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)
2. **Notice to Buyer: This is a disability income protection policy.**
3. The **Benefits Commence** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot exceed:
  - 1) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;
  - 2) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or
  - 3) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.
4. The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months. If the plan design includes both short term and long term disability benefits, the combined short term disability and long term disability **Maximum Duration of Benefits** cannot be less than 6 months.

**Illinois:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **For Your Questions and Complaints:**  
Illinois Department of Insurance  
Consumer Services Station  
Springfield, Illinois 62767  
**Consumer Assistance:** 1(866) 445-5364  
**Officer of Consumer Health Insurance:** 1(877) 527-9431
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

**STATE OF ILLINOIS**  
**The Religious Freedom Protection and Civil Union Act**  
**Effective June 1, 2011**

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by



the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms “spouse,” “family,” “immediate family,” “dependent,” “next of kin,” and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms “marriage” or “married,” or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance’s website at <https://idoi.illinois.gov>.

#### Indiana:

1. **For Your Questions and Complaints:**

Public Information/Market Conduct  
Indiana Department of Insurance  
311 W. Washington St. Suite 300  
Indianapolis, IN 46204-2787  
1(317) 232-2395

#### Kansas:

1. The following requirement applies to you:

**Policy Interpretation:** *Who interprets Policy terms and conditions?*

Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

#### Louisiana:

1. The following requirement applies to you:

**Reinstatement after Military Service:** *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents’ coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents’ release from active military service.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage ended;
- 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
- 3) be subject to all the terms and provisions of The Policy.

#### Maine:

1. **NOTICE:** The benefits under this policy are subject to reduction due to other sources of income.

This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under this policy.

Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker’s Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

What comprises other sources of income under this policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully**. A full description of the plans and types of

plans considered to be other sources of income under this policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.

2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

3. The following requirement applies to you:

**Reinstatement:** *Can my coverage be reinstated after it ends?*

We will reinstate The Policy upon receipt of all current and late premiums if:

- 1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
- 2) all current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

**Massachusetts:**

1. The following continuation requirement applies to you:

In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

- 1) 90 days from the date You were no longer eligible for coverage as an Active Employee;
- 2) the date You become eligible for similar benefits under another group plan;
- 3) the last day of the period for which required premium is made;
- 4) the date the group insurance policy terminates; or
- 5) the date Your Employer ceases to be a Participant Employer, if applicable.

**Michigan:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

**Minnesota:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

**Missouri:**

1. The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

**Montana:**

1. **NOTICE:** Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.
2. Pregnancy will be covered, the same as any other Sickness, anything in The Policy to the contrary notwithstanding.
3. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath,

chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

#### New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Exclusions and Limitations** section, is 3 consecutive months. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until You have been treatment free or continuously insured for 9 consecutive months, or less respectively, if shown in the Certificate.
4. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
5. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
6. **Notice: READ YOUR CERTIFICATE CAREFULLY** - You have a 30 day right to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days from the later of Your original Certificate Effective Date or the date The Policy was received by the Policyholder. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
7. **Notice:** The Policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

#### New York:

1. The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that represents or compensates for Your loss of earnings.
2. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

- 1) you are both legally and mentally competent to consent to contract in the state in which you reside;
- 2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
- 3) you have been living together on a continuous basis prior to the date of the application;
- 4) neither of you have been registered as a member of another domestic partnership within the last six months; and
- 5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

- 1) a joint bank account;
- 2) a joint credit card or charge card;
- 3) joint obligation on a loan;
- 4) status as an authorized signatory on the partner's bank account, credit card or charge card;
- 5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
- 6) listing of both partners as tenants on the lease of the shared residence;
- 7) shared rental payments of residence (need not be shared 50/50)
- 8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- 9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
- 10) shared household budget for purposes of receiving government benefits;
- 11) status of one as representative payee for the other's government benefits;
- 12) joint responsibility for child care (e.g., school documents, guardianship);

- 13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
- 14) execution of wills naming each other as executor and/or beneficiary;
- 15) designation as beneficiary under the other's life insurance policy;
- 16) designation as beneficiary under the other's retirement benefits account;
- 17) mutual grant of durable power of attorney;
- 18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- 19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
- 20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

**North Carolina:**

- 1) The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
- 2) The **Other Income Benefits** definition will not include a mandatory "no fault" automobile insurance plan.
- 3) You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
- 4) The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
- 5) Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
- 6) The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.
- 7) The **Claims to be Paid** provision is amended to state that We may pay up to \$3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
- 8) **Notice of Claim** may also be given to Our representative, if applicable.
- 9) **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
  1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
  2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

**IMPORTANT TERMINATION INFORMATION**

**YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.**

**THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.**

**PRE-EXISTING LIMITATION  
READ CAREFULLY**

**NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THIS CERTIFICATE.**

**READ YOUR CERTIFICATE CAREFULLY.**

**Oregon:**

1. The following Jury Duty continuation applies for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

**Rhode Island:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

**South Carolina:**

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
  - 1) the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
  - 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

**South Dakota:**

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.
2. The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

**Texas:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable
2. **NOTICE:**

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

**Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [gbdcustomerservice@thehartford.com](mailto:gbdcustomerservice@thehartford.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

**Call with a question: 1-800-252-3439**

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

### **Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [gbdcustomerservice@thehartford.com](mailto:gbdcustomerservice@thehartford.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

**Llame con sus preguntas al: 1-800-252-3439**

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **Utah:**

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

### **Vermont:**

1. The following requirement applies:

**Purpose:** Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

**Definitions, Terms, Conditions and Provisions:** The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

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

**CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE**

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

**Virginia:**

1. **For Your Questions and Complaints:**  
**State Corporation Commission**  
**Life and Health Division**  
**Bureau of Insurance**  
P.O. Box 1157  
Richmond, VA 23218  
1(804) 371-9691 (inside Virginia)  
1(877) 310-6560 (outside Virginia)

**Washington:**

1. The following continuation applies to you:

General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

**Wisconsin:**

1. **For Your Questions and Complaints:**  
To request a Complaint Form:  
Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1(800) 236-8517 (outside of Madison)  
1(608) 266-0103 (in Madison)



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

**CERTIFICATE OF INSURANCE**

**Policyholder:** City of Victoria

**Policy Number:** GRH-891798

**Policy Effective Date:** January 1, 2024

**Policy Anniversary Date:** January 1

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

A handwritten signature in dark ink, appearing to read "Kevin Barnett".

Kevin Barnett, Secretary

A handwritten signature in dark ink, appearing to read "Jonathan R. Bennett".

Jonathan Bennett, President

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**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

*A note on capitalization in this certificate:*

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.



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GBD-1200 A01 (10/08) (TX)	

## SCHEDULE OF INSURANCE

The Policy of short term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness or pregnancy.

### **Cost of Coverage:**

You must contribute toward the cost of coverage.

### **Disclosure of Payment to the Policyholder:**

We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:

- 1) audit;
- 2) marketing communication services; and
- 3) other administrative expenses.

### **Eligible Class(es) For Coverage:**

All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least 30 hours weekly

**Annual Enrollment Period:** as determined by Your Employer on a yearly basis.

### **Eligibility Waiting Period for Coverage:**

- 1) None - if You are working for the Employer on the Policy Effective Date; or
- 2) 30 days - if You start working for the Employer after the Policy Effective Date.

The time period(s) referenced above are continuous.

### **Benefits Commence:**

- 1) for Disability caused by Injury: on the 15<sup>th</sup> day of Total Disability or Disabled and Working;
- 2) for Disability caused by Sickness: on the 15<sup>th</sup> day of Total Disability or Disabled and Working.

### **Weekly Benefit:** The lesser of:

- 1) 60% of Your Pre-disability Earnings; or
- 2) \$1,000;

reduced by Other Income Benefits.

**Minimum Weekly Benefit:** 10% of Your Pre-disability Earnings.

### **Maximum Duration of Benefits Payable:**

- 1) if Your Disability is the result of a Pre-existing Condition: 4 week(s) if caused by Injury or Sickness; otherwise
- 2) 11 weeks if caused by Injury; or
- 3) 11 weeks if caused by Sickness

### **Additional Benefits:**

#### **Disabled and Working Benefit**

see benefit

#### **Rehabilitative Employment Benefit**

see benefit

GBD-1200 B01 (10/08) (Rev-1) (TX) (Rev-1)

## ELIGIBILITY AND ENROLLMENT

### **Eligible Persons:** *Who is eligible for coverage?*

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

GBD-1200 D01 (10/08)

**Eligibility for Coverage:** *When will I become eligible?*

You will become eligible for coverage on the later of:

- 1) the Policy Effective Date; or
- 2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

GBD-1200 D02 (10/08)

**Enrollment:** *How do I enroll for coverage?*

To enroll for coverage You must:

- 1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
- 2) deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:

- 1) You must give Us Evidence of Insurability satisfactory to Us; and
- 2) You may only enroll:
  - a) during an Annual Enrollment Period designated by the Policyholder; or
  - b) within 31 days of the date You have a Change in Family Status.

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

GBD-1200 D03 (10/08) (Rev-1)

**Evidence of Insurability:** *What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to Us?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us;
- 2) a medical examination;
- 3) attending Physicians' statements; and
- 4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

- 1) Your Weekly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- 2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

GBD-1200 D04 (10/08)

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

A Change in Family Status occurs when:

- 1) You get married;
- 2) You and Your spouse divorce;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse dies;
- 5) Your child is no longer financially dependent on You or dies;
- 6) Your spouse is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

GBD-1200 D05 (10/08)

## PERIOD OF COVERAGE

**Effective Date:** *When does my coverage start?*

Your coverage will start on the earliest of:

- 1) the date You become eligible, if You enroll or have enrolled by then;
- 2) the date on which You enroll, if You do so within 31 days after the date You are eligible;

- 3) the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or
- 4) the Policy Anniversary Date following the Annual Enrollment Period if You enroll, during an Annual Enrollment Period.

GBD-1200 E01 (10/08)

**Deferred Effective Date:** *When will my effective date for coverage or a change in my coverage be deferred?*

If You are absent from work due to:

- 1) accidental bodily injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy;

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

GBD-1200 E05 (10/08)

**Changes in Coverage:** *Can I change my benefit options?*

You may change Your benefit option only:

- 1) during an Annual Enrollment Period; or
- 2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

*When will a requested change in benefit option take effect?*

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

- 1) the Policy Anniversary Date following the Annual Enrollment Period; or
- 2) the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

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

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

Any such increase in coverage is subject to the following provisions:

- 1) Deferred Effective Date; and
- 2) Pre-existing Conditions Limitation.

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

Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings.

However, no increase in coverage will be effective unless on that date You:

- 1) are an Active Employee; and
- 2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

*What happens if the Employer changes The Policy?*

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

- 1) the Deferred Effective Date provision; and
- 2) Pre-existing Conditions Limitation.

GBD-1200 E07 (10/08) (Rev-1)

**Continuity From A Prior Policy:** *Is there continuity of coverage from a Prior Policy?*

If You were:

- 1) insured under the Prior Policy; and
- 2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

*Is my coverage under The Policy subject to the Pre-existing Condition Limitation?*

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

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

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

- 1) the Weekly Benefit which was paid by the Prior Policy; or
- 2) the Weekly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

GBD-1200 E08 (10/08)

**Termination:** *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the date The Policy no longer insures Your class;
- 3) the date premium payment is due but not paid;
- 4) the last day of the period for which You make any required premium contribution;
- 5) the date Your Employer terminates Your employment; or
- 6) the date You cease to be a Full-time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

GBD-1200 E10 (10/08)

**Continuation Provisions:** *Can my coverage be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium; and
- 3) terminates if:
  - a) The Policy terminates; or
  - b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

**Military Leave of Absence:** If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 week(s), or longer if required by other applicable law. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

**Family and Medical Leave:** If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

GBD-1200 E13 (10/08) (Rev-1)

**Coverage while Disabled:** *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

- 1) while You remain Disabled; and
- 2) until the end of the period for which You are entitled to receive short term Disability Benefits;

provided premiums for Your coverage continued to be paid.

After short term Disability Benefit payments have ceased, Your insurance will be reinstated, provided:

- 1) You return to work for one full day as a Full-time Active Employee in an eligible class;
- 2) The Policy remains in force; and
- 3) the premiums for You were paid during Your Disability, and continue to be paid.

**Extension of Benefits for Disability:** *Do my benefits continue if The Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

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

Termination of The Policy for any reason will have no effect on Our liability under this provision.

GBD-1200 E21 (10/08)

## BENEFITS

**Disability Benefit:** *What are my Disability Benefits under The Policy?*

If, while covered under this Benefit, You:

- 1) become Disabled;
- 2) remain Disabled; and
- 3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:

- 1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
- 2) any income received from the Employer for the period You are Disabled.

**Minimum Weekly Benefit:** *Is there a Minimum Weekly Benefit?*

Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

**Partial Week Payment:** *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay 1/5 of the Weekly Benefit for each day You were Disabled.

GBD-1200 F04 (10/08)

**Recurrent Disability:** *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*

When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

- 1) due to the same cause; or
- 2) due to a related cause; and
- 3) within 15 consecutive calendar days of the return to work;

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

If You return to work as an Active Employee for 15 consecutive calendar days or more, any recurrence of a Disability will be treated as a new Disability.

**Period of Disability** means a continuous length of time during which You are Disabled under The Policy.

GBD-1200 F09 (10/08)

**Multiple Causes:** *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

- 1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
- 2) any Exclusions and Pre-existing Conditions Limitations will apply to the new cause of Disability.

GBD-1200 F10 (10/08)

**Termination of Payment:** *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) the date You are no longer under the Regular Care of a Physician;

- 4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
- 5) the date of Your death;
- 6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
- 7) the last day benefits are payable according to the Maximum Duration of Benefits;
- 8) the date Your Current Weekly Earnings are equal to or greater than 80% of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

GBD-1200 F19 (10/08)

**Disabled and Working Benefits:** *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, We will use the following calculation to determine Your Weekly Benefit:

$$\text{Weekly Benefit} = \frac{(A - B) \times C}{A}$$

Where

**A** = Your Weekly Pre-disability Earnings.

**B** = Your Current Weekly Earnings.

**C** = The Weekly Benefit payable if You were Totally Disabled.

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your Weekly Benefit by the Rehabilitative Employment Benefit.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

**Partial Week Payment:** *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay 1/5 of the Weekly Benefit for each day You were Disabled.

GBD-1200 F20 (10/08)

**Rehabilitative Employment Benefit:** *What happens to my benefits if I accept Rehabilitative Employment?*

If, while You are Totally Disabled or Disabled and Working, You accept Rehabilitative Employment, We will continue to pay a Weekly Benefit.

The Weekly Benefit We will pay will be equal to Your Total Disability Weekly Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the Weekly Benefit and total income received from Rehabilitative Employment may not exceed 100% of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the Weekly Benefit paid by Us will be reduced by the excess amount.

We reserve the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Policy.

If You remain Totally Disabled or Disabled and Working after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit or Disabled and Working Benefit, subject to the Maximum Payment Period for such benefit.

GBD-1200 F24 (10/08)

## EXCLUSIONS AND LIMITATIONS

**Exclusions:** *What Disabilities are not covered?*

The Policy does not cover, and We will not pay a benefit for, any Disability:

- 1) unless You are under the Regular Care of a Physician;
- 2) that is caused or contributed to by war or act of war, whether declared or not;
- 3) caused by Your commission of or attempt to commit a felony;
- 4) caused or contributed to by Your being engaged in an illegal occupation;

- 5) caused or contributed to by an intentionally self-inflicted Injury;
- 6) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
- 7) sustained as a result of doing any work for pay or profit for another employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

- 1) was sponsored by Your Employer; and
- 2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

GBD-1200 G01 (10/08)

**Pre-existing Condition Limitation:** *Are benefits limited for Pre-existing Conditions?*

We will only pay benefits, or an increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition for up to 4 week(s), unless, at the time You become Disabled:

- 1) You have not received Medical Care for the condition for 3 consecutive months while insured under The Policy; or
- 2) You have been continuously insured under The Policy for 12 consecutive months.

**Pre-existing Condition** means any disease or physical condition related to or resulting from accidental bodily injury or sickness for which You received Medical Care during the 3 consecutive month period that ends the day before:

- 1) Your effective date of coverage; or
- 2) the effective date of a Change in Coverage.

**Medical Care** is received when a Physician or other health care provider:

- 1) is consulted or gives medical advice; or
- 2) recommends, prescribes, or provides Treatment.

**Treatment** includes but is not limited to:

- 1) medical examinations, tests, attendance or observation; and
- 2) use of drugs, medicines, medical services, supplies or equipment.

GBD-1200 G04 (10/08) (Rev-2) (TX)

## GENERAL PROVISIONS

**Notice of Claim:** *When should I notify the Company of a claim?*

You must give Us written, electronic or telephonic notice of a claim within 30 days after Disability occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address, and the Policy Number.

GBD-1200 H01 (10/08) (TX)

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

We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written, electronic or telephonic proof which fully describes the nature and extent of Your claim.

Proof of Loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.

GBD-1200 H02 (10/08)

**Proof of Loss:** *What is Proof of Loss?*

Proof of Loss may include but is not limited to the following:

- 1) documentation of:
  - a) the date Your Disability began;
  - b) the cause of Your Disability;
  - c) the prognosis of Your Disability;
  - d) Your Pre-disability Earnings, Current Weekly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
  - e) evidence that You are under the Regular Care of a Physician;



- 2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 3) the names and addresses of all:
  - a) Physicians or other qualified medical professionals You have consulted;
  - b) hospitals or other medical facilities in which You have been treated; and
  - c) pharmacies which have filled Your prescriptions within the past three years;
- 4) Your signed authorization for Us to obtain and release:
  - a) medical, employment and financial information; and
  - b) any other information We may reasonably require;
- 5) disclosure of all information and documentation required by Us relating to Other Income Benefits;
- 6) proof that You and Your dependents have applied for all Other Income Benefits which are available; and
- 7) disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

GBD-1200 H03 (10/08) (Rev-1)

**Additional Proof of Loss:** *What Additional Proof of Loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

- 1) meet and interview with Our representative; and
- 2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

- 1) at Our expense; and
- 2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

GBD-1200 H04 (10/08)

**Sending Proof of Loss:** *When must Proof of Loss be given?*

Written Proof of Loss must be sent to Us within 90 days following the completion of the Benefits Commence period. If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not reasonably possible to give proof within the required time; and
- 2) proof is given as soon as reasonably possible; but
- 3) not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, Our receipt of proof within 30 days of the request will allow us to continue the adjudication of Your claim.

GBD-1200 H05 (10/08) (TX)

**Claim Payment:** *When are benefit payments issued?*

When We determine that You;

- 1) are Disabled; and
- 2) eligible to receive benefits;

We will pay accrued benefits at the end of each week that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Benefits may be subject to interest payments as required by applicable law.

GBD-1200 H06 (10/08)

**Claims to be Paid:** *To whom will benefits for my claim be paid?*

All payments are payable to You or Your assignee. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent;

then We may pay up to \$1,000 to a person who is Related to You. Any such payment shall fulfill Our responsibility for the amount paid.

**Claim Denial:** *What notification will I receive if my claim is denied?*

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

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

GBD-1200 H09 (10/08) (TX)

**Claim Appeal:** *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

- 1) must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
  - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to Your claim; and
- 3) may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

GBD-1200 H10 (10/08) (TX)

**Social Security:** *When should I apply for Social Security Benefits?*

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

- 1) follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

GBD-1200 H11 (10/08) (TX)

**Plan Offered by a State or Municipal Government:** *When must I apply for benefits under a plan offered by a state or municipal government?*

You must apply for disability benefits under a plan offered by a state or municipal government, such as those offered by a public employee retirement system or state teacher retirement system, when the length of Your Disability meets the minimum duration required to apply for such benefits and You are eligible under the plan. You must apply within 45 days from the date of Our request. If the administrator of that alternative plan denies Your eligibility for benefits, You will be required to follow the process established by the administrator to reconsider the denial.

GBD-1200 H34 (10/08)

**Benefit Estimates:** *How does the Company estimate Disability benefits under the United States Social Security Act or an alternative plan offered by a state or municipal government?*

We reserve the right to reduce Your Weekly Benefit by estimating the Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, that You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Weekly Benefit by the estimated amount.

Your Weekly Benefit will not be reduced by estimated Social Security disability benefits nor disability benefits under an alternative plan offered by a state or municipal government if:

- 1) You apply for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government if applicable, and pursue all required appeals in accordance with the Social Security and Plan Offered by a State or Municipal Government provisions; and
- 2) You have signed a form authorizing the Social Security Administration, or the administrator of the alternative plan offered by a state or municipal government if applicable, to release information about awards directly to Us; and
- 3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Weekly Benefit by an estimated amount and:

- 1) You or Your dependent are later awarded Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, We will adjust Your Weekly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
- 2) Your application for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, has been denied, We will adjust Your Weekly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals, or similar level under an alternative plan offered by a state or municipal government when available.

If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were higher than We estimated, and if Your Weekly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

GBD-1200 H12 (10/08) (Rev-1)

**Overpayment:** *When does an overpayment occur?*

An overpayment occurs:

- 1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
- 2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- 1) retroactive awards received from sources listed in the Other Income Benefits definition;
- 2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
- 3) misstatement;
- 4) fraud; or
- 5) any error We may make.

GBD-1200 H13 (10/08)

**Overpayment Recovery:** *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
  - a) You;
  - b) any other organization;
  - c) any other insurance company;
  - d) any other person to or for whom payment was made; and
  - e) Your estate;
- 2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Weekly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- 3) refer Your unpaid balance to a collection agency; and
- 4) pursue and enforce all legal and equitable rights in court.

GBD-1200 H14 (10/08)

**Subrogation:** *What are Our subrogation rights?*

If You:

- 1) suffer a Disability caused, in full or in part, by the act or omission of any person or legal entity;
- 2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
- 3) do not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that You do not intend to do so;

then We will be subrogated to any rights You may have against a Third Party and may bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Disability.

**Third Party** as used in this provision, means:

- 1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
- 2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

GBD-1200 H15 (10/08) (Rev-1) (TX)

**Reimbursement:** *What are Our reimbursement rights?*

We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:

- 1) a legal judgment;
- 2) an arbitration award; or
- 3) a settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:

- 1) the entire amount of the benefit payment(s) made or required to be made by Us; or
- 2) the total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds. We have the right of first reimbursement regardless of:

- 1) whether You are made whole;
- 2) how the recovered funds are characterized; or
- 3) whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:

- 1) agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and
- 2) will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

**Third Party** as used in this provision, means:

- 1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
- 2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

GBD-1200 H16 (10/08) (Rev-1)

**Legal Actions:** *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date Proof of Loss is given; or
- 2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

GBD-1200 H17 (10/08)

**Insurance Fraud:** *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

GBD-1200 H18 (10/08)

**Misstatements:** *What happens if facts are misstated?*

If material facts about You were not stated accurately:

- 1) Your premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

GBD-1200 H19 (10/08) (TX)

**Incontestability:** *When can coverage be contested?*

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.  
GBD-1200 H23 (10/08) (Rev-1) (TX)

**Eligibility Determination:** *How will We determine Your eligibility for benefits?*

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

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

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

GBD-1200 H25 (10/08) (TX)

**Physical Examinations and Autopsy:** *Will I be examined during the course of my claim?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as reasonably necessary; and
- 2) to make an autopsy in case of death where it is not forbidden by law.

GBD-1200 H21 (10/08)

**Assignment:** *Are there any rights of assignment?*

You have the right to absolutely assign Your rights and interest under The Policy. We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

You do not have the right to collaterally assign Your rights and interest under The Policy.

GBD-1200 H22 (10/08) (TX)

## DEFINITIONS

**Actively at Work** means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

GBD-1200 C01 (10/08)

**Active Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

GBD-1200 C03 (10/08)

**Current Weekly Earnings** means weekly earnings You receive from:

- 1) Your Employer; and
- 2) other employment;

while You are Disabled and eligible for the Disabled and Working Benefit.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month period just before You became Disabled will count as Current Weekly Earnings.

Current Weekly Earnings also includes the pay You could have received for another job or a modified job if:

- 1) such job was offered to You by Your Employer, or another employer, and You refused the offer; and
- 2) the requirements of the position were consistent with:
  - a) Your education, training and experience; and
  - b) Your capabilities as medically substantiated by Your Physician.

GBD-1200 C09 (10/08) (Rev-1)

**Disability or Disabled** means Total Disability or Disabled and Working Disability.

GBD-1200 C11 (10/08)

**Disabled and Working** means that You are prevented by:

- 1) Injury;
- 2) Sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy;

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time or limited duty basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than 80% of Your Pre-disability Earnings.

GBD-1200 C10 (10/08)

**Employer** means the Policyholder.

GBD-1200 C17 (10/08)

**Essential Duty** means a duty that:

- 1) is substantial, not incidental;
- 2) is fundamental or inherent to the occupation; and
- 3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

GBD-1200 C18 (10/08) (Rev-1)

**Injury** means bodily injury resulting:

- 1) directly from accident; and
- 2) independently of all other causes;

which occurs while You are covered under The Policy. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.

GBD-1200 C20 (10/08)

**Mental Illness** means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

- 1) Mental Retardation;
- 2) Pervasive Developmental Disorders;
- 3) Motor Skills Disorder;
- 4) Substance-Related Disorders;
- 5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- 6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

**Other Income Benefits** means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

- 1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- 2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
- 3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
- 4) mandatory "no fault" automobile insurance plan;
- 5) disability benefits under:
  - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
  - b) the Railroad Retirement Act;
  - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
  - d) similar plan or act;that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
- 6) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
  - a) that begins after You become Disabled; or
  - b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

- 1) disability benefit under Your Employer's Retirement Plan;
- 2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- 3) portion of a judgment or settlement of a claim or lawsuit that represents or compensates for Your loss of earnings, less Our pro rata share of any associated reasonable attorneys' fees and court costs; or
- 4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
  - a) You were receiving it prior to becoming Disabled; or
  - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

(Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.)

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- 1) takes effect after the date benefits become payable under The Policy; and
- 2) is a general increase which applies to all persons who are entitled to such benefits.

**Physician** means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Related to You by blood or marriage.

**Pre-disability Earnings** means Your regular weekly rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day You were Actively at Work before You became Disabled.

However, if You were an hourly paid Active Employee before You became Disabled, Pre-disability Earnings means the product of:

- 1) the average number of hours You worked per week, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:

- 2) Your hourly wage in effect immediately prior to the last day You were Actively at Work before You became Disabled.

GBD-1200 C29 (10/08)

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

GBD-1200 C34 (10/08) (Rev-1)

**Regular Care of a Physician** means that You are being treated by a Physician:

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

GBD-1200 C35 (10/08)

**Rehabilitative Employment** means employment or service which:

- 1) prepares a Disabled person to resume gainful work; and
- 2) is approved, in writing, by Us.

GBD-1200 C37 (10/08)

**Related** means Your spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

GBD-1200 C38 (10/08)

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

- 1) a profit sharing plan;
- 2) thrift, savings or stock ownership plans;
- 3) a non-qualified deferred compensation plan; or
- 4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

GBD-1200 C39 (10/08)

**Sickness** means a Disability which is:

- 1) caused or contributed to by:
  - a) any condition, illness, disease or disorder of the body;
  - b) any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
  - c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or
  - d) pregnancy;
- 2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1) above.

GBD-1200 C40 (10/08)

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

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

Substance includes alcohol and drugs but excludes tobacco and caffeine.

GBD-1200 C42 (10/08)

**The Policy** means the policy which We issued to the Policyholder under the Policy Number shown on the face page.

GBD-1200 C43 (10/08)

**Total Disability or Totally Disabled** means that You are prevented by:

- 1) Injury;
- 2) Sickness;



- 3) Mental Illness;
- 4) Substance Abuse; or
- 5) pregnancy;

from performing the Essential Duties of Your Occupation, and as a result, You are earning 20% or less of Your Pre-disability Earnings.

If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation alone, does not mean that You are disabled from Your Occupation.

GBD-1200 C45 (10/08)

**We, Our, or Us** means the insurance company named on the face page of The Policy.

GBD-1200 C48 (10/08)

**Weekly Benefit** means a weekly sum payable to You while You are Disabled, subject to the terms of The Policy.

GBD-1200 C22 (10/08)

**Your Occupation** means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

GBD-1200 C49 (10/08)

**You or Your** means the person to whom this certificate is issued.

GBD-1200 C50 (10/08)



# HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)

## NONINSURANCE BENEFITS AND SERVICES

### Benefits and Services

In addition to the Insurance coverage, We may offer noninsurance benefits and services to Eligible Persons. Eligible Persons should contact the Policyholder for more information on the services available on their plan.

Eligible Persons can obtain a description and contact information for noninsurance benefits and services by visiting [www.thehartfordatwork.com](http://www.thehartfordatwork.com).

The following benefits terminate upon policy termination:

- Will Preparation Services. These services provide access to an online tool to create a customized will with the help of licensed attorneys, if needed.
- Travel Assistance Related Services. These services provide help for situations that travelers may be facing like replacing a lost passport or arranging for local medical assistance.
- Identity Theft Related Services. These services provide fraud prevention and credit monitoring as well as resolution support if an Eligible Person is the victim of identity theft.
- Funeral Planning Services. These services provide support to Eligible Persons or their beneficiaries to prepare for a funeral with access to online planning and research tools and advisors to answer questions.

The following benefits terminate upon policy termination. If an Eligible Person is receiving benefits when the policy terminates, benefits may continue beyond the policy termination date.

- Employee Assistance Programs. Support is provided for a wide range of social and emotional issues. The program provides for either telephonic or face-to-face counseling sessions.
- Beneficiary Support Services. These services provide emotional, legal or financial guidance, answer benefit-related questions or provide referrals to Eligible Persons or their beneficiaries.

### Optional Enhanced Benefits and Services

The Policyholder may select optional enhanced noninsurance benefits and services for a nominal cost, ranging from \$.01 to \$4.50 monthly, depending on the level of service and the plan design selected. Eligible Persons should contact the Policyholder for more information on the optional services available and cost, if any.

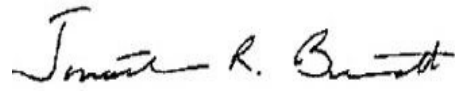
The noninsurance benefits and services provided are offered by third party vendors. While The Hartford has arranged these benefits and services, the third party providers are liable to the Eligible Persons for the provision of such benefits and services. The Hartford is not responsible for the provision of benefits and services nor is it liable for the failure of the provision of the same. Further, The Hartford is not liable to Eligible Persons for the negligent provisions of such benefits

and services by the third party providers. Note that The Hartford in its sole discretion may change vendors or may terminate any noninsurance benefit or service. The Eligible Persons will be given 60 days notice of such termination, unless, the termination is due to circumstances beyond The Hartford's control, such as a vendor terminating its services.

Signed for Hartford Life and Accident Insurance Company



Kevin Barnett, *Secretary*



Jonathan Bennett, *President*

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

### For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:**
  - Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is not protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, Texas 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 12030  
Austin, Texas 78711-2030  
1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

**ERISA INFORMATION  
THE FOLLOWING NOTICE  
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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**1. Plan Name**

For employees of :

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**2. Plan Number**

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**3. Employer/Plan Sponsor**

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**4. Employer Identification Number**

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**5. Type of Plan**

Welfare Benefit Plan providing:

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**6. Plan Administrator**

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**7. Agent for Service of Legal Process**

For the Plan

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For the Policy:

Hartford Life and Accident Insurance Company  
One Hartford Plaza  
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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**8. Sources of Contributions**

**(Group Short Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
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10. The Plan and its records are kept on a Year basis.
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**11. Labor Organizations**

None

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**12. Names and Addresses of Trustees**

None

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**13. Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

### 1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### 2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### 4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

### Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.



## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

### **Claim Procedures for Claims Not Requiring a Determination of Disability**

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

#### **Claims for Benefits**

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

#### **Appealing Denials of Claims for Benefits**

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

#### **Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

#### **Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**Maryland**

**The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

## State Notices

**IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:** There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at <https://www.thehartford.com/>. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

**The Hartford**  
**Group Benefits Division, Customer Service**  
**P.O. Box 2999**  
**Hartford, CT 06104-2999**  
**1-800-523-2233**

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

### **Alaska:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

### **Arizona:**

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

### **Arkansas:**

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:  
Arkansas Insurance Department  
1 Commerce Way, Suite 102  
Little Rock, AR 72202
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

### **California:**

1. **NOTICE: READ YOUR CERTIFICATE CAREFULLY**  
You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

**Eligibility Determination:** *How will We determine Your eligibility for benefits?*

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

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

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

3. **For Your Questions and Complaints:**

State of California Insurance Department  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
**Toll Free:** 1(800) 927-HELP  
**TDD Number:** 1(800) 482-4833  
**Web Address:** [www.insurance.ca.gov](http://www.insurance.ca.gov)

**Colorado:**

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions.
3. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
4. The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

**Complications of Pregnancy** means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:

- 1) acute nephritis or nephrosis;
- 2) cardiac decompensation;
- 3) missed abortion; and
- 4) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include:

- 1) pre-eclampsia;
- 2) placenta previa;
- 3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
- 4) termination of ectopic pregnancy;
- 5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;

- 6) non-elective Cesarean section; and
- 7) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:

- 1) elective Cesarean section;
  - 2) false labor, occasional spotting, or morning sickness;
  - 3) hyperemesis gravidarum; or
  - 4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.
5. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

6. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

#### Florida:

1. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

#### Georgia:

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

#### Idaho:

1. **For Your Questions and Complaints:**  
Idaho Department of Insurance  
Consumer Affairs  
700 W State Street, 3rd Floor  
PO Box 83720  
Boise, ID 83720-0043  
**Toll Free:** 1-800-721-3272  
**Web Address:** [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)
2. **Notice to Buyer: This is a disability income protection policy.**
3. The **Elimination Period** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot exceed:
  - 1) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;
  - 2) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or
  - 3) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.
4. The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months.

#### Illinois:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **For Your Questions and Complaints:**  
Illinois Department of Insurance  
Consumer Services Station  
Springfield, Illinois 62767  
**Consumer Assistance:** 1(866) 445-5364  
**Officer of Consumer Health Insurance:** 1(877) 527-9431
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

**STATE OF ILLINOIS**  
**The Religious Freedom Protection and Civil Union Act**  
**Effective June 1, 2011**

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are

entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms “spouse,” “family,” “immediate family,” “dependent,” “next of kin,” and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms “marriage” or “married,” or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance’s website at <https://idoi.illinois.gov>.

#### **Indiana:**

1. **For Your Questions and Complaints:**

Public Information/Market Conduct  
Indiana Department of Insurance  
311 W. Washington St. Suite 300  
Indianapolis, IN 46204-2787  
1(317) 232-2395

#### **Kansas:**

1. The following requirement applies to you:

**Policy Interpretation:** *Who interprets Policy terms and conditions?*

Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

#### **Louisiana:**

1. The following requirement is applicable to you:

**Reinstatement after Military Service:** *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents’ coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents’ release from active military service.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage ended;
- 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
- 3) be subject to all the terms and provisions of The Policy.

#### **Maine:**

1. **NOTICE:** The benefits under the policy are subject to reduction due to other sources of income.

This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under the policy.

Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker’s Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.



What comprises other sources of income under the policy is determined by the nature of the policyholder.

Therefore, we strongly urge you to **Read Your Certificate Carefully**. A full description of the plans and types of plans considered to be other sources of income under the policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.

2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

3. The following **requirement is applicable to you:**

**Reinstatement:** *Can my coverage be reinstated after it ends?*

We will reinstate The Policy upon receipt of all current and late premiums if:

- 1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
- 2) all current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

#### **Massachusetts:**

1. The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.
2. The following continuation requirement is applicable to you

In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

- 1) 90 days from the date You were no longer eligible for coverage as an Active Employee;
- 2) the date You become eligible for similar benefits under another group plan;
- 3) the last day of the period for which required premium is made;
- 4) the date the group insurance policy terminates; or
- 5) the date Your Employer ceases to be a Participant Employer, if applicable.

#### **Michigan:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

#### **Minnesota:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

#### **Missouri:**

1. The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

#### **Montana:**

1. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

2. Pregnancy will be covered, the same as any other sickness, anything in The Policy to the contrary notwithstanding.
3. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

#### New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Exclusions and Limitations** section, is 3 consecutive months. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until You have been treatment free or continuously insured for 9 consecutive months, or less respectively, if shown in the Certificate.
4. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
5. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
6. **Notice: READ YOUR CERTIFICATE CAREFULLY** - You have a 30 day right to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days from the later of Your original Certificate Effective Date or the date The Policy was received by the Policyholder. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
7. **Notice:** The Policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

#### New Jersey:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions and domestic partners, provided You continue to meet the requirements described in the domestic partner affidavit, civil union license or civil union certificate or as required by law. Same sex relationships entered into under the laws of another State or Country, which closely approximate a civil union or a domestic partnership under New Jersey law, will be recognized as civil unions or domestic partners under New Jersey law.

#### New Mexico:

1. The **Surviving Children** definition within the **Survivor Income Benefit**, if included in Your Certificate, will include children up to age 26.

#### New York:

1. The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that represents or compensates for Your loss of earnings.
2. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

- 1) you are both legally and mentally competent to consent to contract in the state in which you reside;
- 2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
- 3) you have been living together on a continuous basis prior to the date of the application;
- 4) neither of you have been registered as a member of another domestic partnership within the last six months; and
- 5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

- 1) a joint bank account;
- 2) a joint credit card or charge card;
- 3) joint obligation on a loan;
- 4) status as an authorized signatory on the partner's bank account, credit card or charge card;
- 5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
- 6) listing of both partners as tenants on the lease of the shared residence;
- 7) shared rental payments of residence (need not be shared 50/50)
- 8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- 9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
- 10) shared household budget for purposes of receiving government benefits;
- 11) status of one as representative payee for the other's government benefits;
- 12) joint responsibility for child care (e.g., school documents, guardianship);
- 13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
- 14) execution of wills naming each other as executor and/or beneficiary;
- 15) designation as beneficiary under the other's life insurance policy;
- 16) designation as beneficiary under the other's retirement benefits account;
- 17) mutual grant of durable power of attorney;
- 18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- 19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
- 20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

#### North Carolina:

1. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. The **Other Income Benefits** definition will not include a mandatory "no-fault" automobile insurance plan.
3. You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4. The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5. Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
6. The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.
7. The **Claims to be Paid** provision is amended to state that We may pay up to \$3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
8. **Notice of Claim** may also be given to Our representative, if applicable.
9. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
  1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
  2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

## IMPORTANT TERMINATION INFORMATION

**YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.**

**THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.**

### **PRE-EXISTING LIMITATION READ CAREFULLY**

**NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THE CERTIFICATE.**

**READ YOUR CERTIFICATE CAREFULLY.**

#### **Oregon:**

1. The definition of **Surviving Spouse** within the **Survivor Income Benefit** will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Surviving Children** definition within the **Survivor Income Benefit** will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

#### **Rhode Island:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

#### **South Carolina:**

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
  - 1) the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
  - 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

#### **South Dakota:**

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.
2. The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

#### **Texas:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable
2. **NOTICE:**

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

### **Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [gbdcustomerservice@thehartford.com](mailto:gbdcustomerservice@thehartford.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

**Call with a question: 1-800-252-3439**

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

### **Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [gbdcustomerservice@thehartford.com](mailto:gbdcustomerservice@thehartford.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

**Llame con sus preguntas al: 1-800-252-3439**

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **Utah:**

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

### **Vermont:**

1. The following requirement applies:

**Purpose:** Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

**Definitions, Terms, Conditions and Provisions:** The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

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

**CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE**

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

2. Vermont Mental Health and Substance Abuse Exclusion and Limitation Parity:  
If You become Disabled as a legal resident of Vermont and The Policy covers 25 or more legal residents of Vermont, the following applies:
  - a. Disability due to Mental Illness or Substance Abuse may not be excluded from coverage; and
  - b. the Maximum Duration of Benefits for Disability due to Mental Illness or Substance Abuse may not be limited. The Maximum Duration of Benefits shown in the Schedule of Insurance shall apply to You.

**Virginia:**

1. **For Your Questions and Complaints:**  
**State Corporation Commission**  
**Life and Health Division**  
**Bureau of Insurance**  
P.O. Box 1157  
Richmond, VA 23218  
1(804) 371-9691 (inside Virginia)  
1(877) 310-6560 (outside Virginia)

**Washington:**

1. The following continuation applies to you:

General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

**Wisconsin:**

**1. For Your Questions and Complaints:**

To request a Complaint Form:

Office of the Commissioner of Insurance

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

1(800) 236-8517 (outside of Madison)

1(608) 266-0103 (in Madison)



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

**CERTIFICATE OF INSURANCE**

**Policyholder:** City of Victoria

**Policy Number:** GLT-891798

**Policy Effective Date:** January 1, 2024

**Policy Anniversary Date:** January 1

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, Secretary

Jonathan Bennett, President

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**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

*A note on capitalization in this certificate:*

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.



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GBD-1200 A01 (10/08) (TX)	

## SCHEDULE OF INSURANCE

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy.

### **Cost of Coverage:**

You must contribute toward the cost of coverage.

### **Disclosure of Payment to the Policyholder:**

We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:

- 1) audit;
- 2) marketing communication services; and
- 3) other administrative expenses.

### **Eligible Class(es) For Coverage:**

All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least 30 hours weekly

**Annual Enrollment Period:** as determined by Your Employer on a yearly basis.

### **Eligibility Waiting Period for Coverage:**

- 1) None - if You are working for the Employer on the Policy Effective Date; or
- 2) The first day of the month following 30 days of employment - if You start working for the Employer after the Policy Effective Date.

The time period(s) referenced above are continuous.

### **Elimination Period:**

90 day(s)

**Maximum Monthly Benefit:** \$5,000

**Minimum Monthly Benefit:** \$100

**Benefit Percentage:** 60%

### **Maximum Duration of Benefits**

#### **Maximum Duration of Benefits Table**

<b>Age When Disabled</b>	<b>Benefits Payable</b>
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

### **Additional Benefit:**

#### **Family Care Credit Benefit**

see benefit

#### **Survivor Income Benefit**

The Survivor Income Benefit is calculated as 3 times the lesser of:

- 1) Your Monthly Benefit in effect the last full calendar month prior to the date of Your death; or
- 2) The Maximum Monthly Benefit.

If You died before receiving a full calendar month benefit, the Survivor Income Benefit will be 3 times Your Monthly Benefit as of Your date of death.

**Workplace Modification Benefit**

see benefit

GBD-1200 B04 (10/08) (Rev-1) (TX) (Rev-1)

## **ELIGIBILITY AND ENROLLMENT**

**Eligible Persons:** *Who is eligible for coverage?*

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

GBD-1200 D01 (10/08)

**Eligibility for Coverage:** *When will I become eligible?*

You will become eligible for coverage on the later of:

- 1) the Policy Effective Date; or
- 2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

GBD-1200 D02 (10/08)

**Enrollment:** *How do I enroll for coverage?*

To enroll for coverage You must:

- 1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
- 2) deliver it to Your Employer.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:

- 1) You must give Us Evidence of Insurability satisfactory to Us; and
- 2) You may only enroll:
  - a) during an Annual Enrollment Period designated by the Policyholder; or
  - b) within 31 days of the date You have a Change in Family Status.

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

GBD-1200 D03 (10/08) (Rev-1)

**Evidence of Insurability:** *What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to Us?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us;
- 2) a medical examination;
- 3) attending Physicians' statements; and
- 4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

- 1) Your Monthly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- 2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

GBD-1200 D04 (10/08)

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

A Change in Family Status occurs when:

- 1) You get married;
- 2) You and Your spouse divorce;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse dies;

- 5) Your child is no longer financially dependent on You or dies;
  - 6) Your spouse is no longer employed, which results in a loss of group insurance; or
  - 7) You have a change in classification from part-time to full-time or from full-time to part-time.
- GBD-1200 D05 (10/08)

## PERIOD OF COVERAGE

### **Effective Date:** *When does my coverage start?*

Your coverage will start on the earliest of:

- 1) the date You become eligible, if You enroll or have enrolled by then;
- 2) the date on which You enroll, if You do so within 31 days after the date You are eligible;
- 3) the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or
- 4) the Policy Anniversary Date following the Annual Enrollment Period if You enroll, for benefit amounts not requiring Evidence of Insurability, during an Annual Enrollment Period.

GBD-1200 E01 (10/08)

### **Deferred Effective Date:** *When will my effective date for coverage or a change in my coverage be deferred?*

If You are absent from work due to:

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

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

GBD-1200 E05 (10/08)

### **Changes in Coverage:** *Can I change my benefit options?*

You may change Your benefit option only:

- 1) during an Annual Enrollment Period; or
- 2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

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

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

- 1) the Policy Anniversary Date following the Annual Enrollment Period; or
- 2) the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

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

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

Any such increase in coverage is subject to the following provisions:

- 1) Deferred Effective Date; and
- 2) Pre-existing Conditions Limitation.

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

Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

- 1) are an Active Employee; and
- 2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

### *What happens if the Employer changes The Policy?*

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

- 1) the Deferred Effective Date provision; and
- 2) Pre-existing Conditions Limitation.

GBD-1200 E07 (10/08) (Rev-1)

**Continuity From A Prior Policy:** *Is there continuity of coverage from a Prior Policy?*

If You were:

- 1) insured under the Prior Policy; and
- 2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

*Is my coverage under The Policy subject to the Pre-existing Condition Limitation?*

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

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

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

- 1) the Monthly Benefit which was paid by the Prior Policy; or
- 2) the Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

*Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?*

If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Full-time Active Employee before the Policy Effective Date, then, if within 6 months of Your return to work:

- 1) You have a recurrence of the same disability while covered under The Policy; and
- 2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

GBD-1200 E08 (10/08)

**Termination:** *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the date The Policy no longer insures Your class;
- 3) the date premium payment is due but not paid;
- 4) the last day of the period for which You make any required premium contribution;
- 5) the date Your Employer terminates Your employment; or
- 6) the date You cease to be a Full-time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

GBD-1200 E10 (10/08)

**Continuation Provisions:** *Can my coverage be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium; and
- 3) terminates if:
  - a) The Policy terminates; or
  - b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

**Military Leave of Absence:** If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

**Family and Medical Leave:** If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.  
GBD-1200 E13 (10/08) (Rev-1)

**Coverage while Disabled:** *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

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

GBD-1200 E14 (10/08)

**Waiver of Premium:** *Am I required to pay premiums while I am Disabled?*

No premium will be due for You:

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

GBD-1200 E19 (10/08) (Rev-1)

**Extension of Benefits for Disability:** *Do my benefits continue if The Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

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

Termination of The Policy for any reason will have no effect on Our liability under this provision.

GBD-1200 E21 (10/08)

## BENEFITS

**Disability Benefit:** *What are my Disability Benefits under The Policy?*

We will pay You a Monthly Benefit if You:

- 1) become Disabled while insured under The Policy;
- 2) are Disabled throughout the Elimination Period;
- 3) remain Disabled beyond the Elimination Period; and
- 4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

GBD-1200 F01 (10/08)

**Mental Illness and Substance Abuse Benefits:** *Are benefits limited for Mental Illness or Substance Abuse?*

If You are Disabled because of:

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

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:

- 1) for as long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
- 2) if not confined, or after You are discharged and still Disabled, for a total of 24 months for all such disabilities during Your lifetime.

GBD-1200 F05 (10/08)

**Specified Condition Limitation:** *Are benefits limited for any specified conditions?*

If You are Disabled because of any of the following conditions or symptom complexes:

- 1) Chemical and Environmental Illness;

- 2) Chronic Fatigue Illness;
- 3) Musculoskeletal and Connective Tissue Illness;
- 4) other specified conditions:
  - a) post concussive syndrome;
  - b) obstructive sleep apnea;
  - c) narcolepsy, cataplexy and other sleep syndromes;
  - d) fibromyalgia;
  - e) migraines, tension headaches, and cluster headaches;
  - f) irritable bowel disease;
  - g) Crohn's disease;
  - h) celiac disease;
  - i) ulcerative colitis; or
  - j) chronic Lyme disease, and other chronic illnesses due to tick borne infections; or
- 5) self-reported symptoms that have not been attributed to a specific diagnosis with objective and verifiable findings. These symptoms include but are not limited to:
  - a) dizziness;
  - b) fatigue;
  - c) headache;
  - d) loss of energy;
  - e) numbness;
  - f) pain;
  - g) ringing in the ear, or other perceived ear tones;
  - h) stiffness; or
  - i) cognitive dysfunction not supported by objective diagnostic testing;

We will limit the Maximum Duration of Benefits, subject to all other provisions of The Policy.

Benefits will be payable until the earlier of:

- 1) the date benefit payments terminate under the Termination of Payment provision; or
- 2) the date You have received Disability benefit payments from Us for one or more of the diseases specified above for a total of 24 month(s) in Your lifetime.

The period of time referenced above will include the time that one or more of the specified diseases are the working diagnosis of the condition which is a cause of Your Disability.

**Chemical and Environmental Illness** means an allergy or sensitivity to chemicals or the environment, including but not limited to:

- 1) environmental allergies;
- 2) sick building syndrome;
- 3) multiple chemical sensitivity syndromes; or
- 4) chronic toxic encephalopathy including, but not limited to, heavy metal toxicity.

Chemical and Environmental Illness does not include asthma or allergy-induced reactive lung disease.

**Chronic Fatigue Illness** means an Illness that is characterized by a debilitating fatigue in the absence of known medical or psychological conditions, which includes but is not limited to:

- 1) chronic fatigue syndrome as supported by Center for Disease Control Guidelines;
- 2) chronic fatigue immunodeficiency syndrome as supported by Center for Disease Control Guidelines;
- 3) post viral syndrome;
- 4) limbic encephalopathy;
- 5) Epstein-Barr virus infection;
- 6) herpes virus type 6 infection; or
- 7) myalgic encephalomyelitis.

Chronic Fatigue Illness does not include a disorder identified as:

- 1) neoplastic disorder;
- 2) neurologic disorder;
- 3) endocrine disorder;
- 4) hematologic disorder;
- 5) rheumatologic disorder; or
- 6) depression.

**Musculoskeletal and Connective Tissue Illness** means a disease or disorder of the neck and back or sprains and strains of joints and adjacent tissues, including but not limited to:

- 1) cervical, thoracic and lumbosacral and surrounding soft tissue conditions without radiculopathy confirmed by diagnostic testing;
- 2) carpal tunnel or repetitive motion syndrome;
- 3) temporomandibular joint or craniomandibular joint disorder;
- 4) myofascial pain; or
- 5) scoliosis that does not require surgery.

Unless specifically listed above, any other musculoskeletal conditions which have confirmed positive universally accepted diagnostic testing such as but not limited to EMG, MRI, CAT, laboratory tests, etc. are not subject to the limitation.

GBD-1200 F49 (10/08)

**Recurrent Disability:** *What happens if I Recover but become Disabled again?*

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

- 1) due to the same cause; or
- 2) due to a related cause; and
- 3) within 6 months of the return to work,

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

If You return to work as an Active Employee for 6 months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

**Period of Disability** means a continuous length of time during which You are Disabled under The Policy.

**Recover or Recovery** means that You are no longer Disabled and have returned to work with The Employer and premiums are being paid for You.

GBD-1200 F07 (10/08)

**Calculation of Monthly Benefit:**

**Return to Work Incentive:** *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

- 1) multiply Your Pre-disability Earnings by the Benefit Percentage;
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

- 1) the day You first start work; or
- 2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

- 1) multiply Your Monthly Income Loss by the Benefit Percentage;
- 2) compare the result with the Maximum Benefit; and
- 3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

GBD-1200 F12 (10/08) (Rev-1)

**Calculation of Monthly Benefit:** *What happens if the sum of my Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*



If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

GBD-1200 F14 (10/08)

**Minimum Monthly Benefit:** *Is there a Minimum Monthly Benefit?*

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

GBD-1200 F15 (10/08)

**Partial Month Payment:** *How is the benefit calculated for a period of less than a month?*

If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Monthly Benefit for each day You were Disabled.

GBD-1200 F16 (10/08)

**Termination of Payment:** *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) the date You are no longer under the Regular Care of a Physician;
- 4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
- 5) the date of Your death;
- 6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
- 7) the last day benefits are payable according to the Maximum Duration of Benefits Table;
- 8) the date Your Current Monthly Earnings:
  - a) are equal to or greater than 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
  - b) are greater than the lesser of the product of Your Indexed Pre-disability Earnings and the Benefit Percentage or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;
- 9) the date no further benefits are payable under any provision in The Policy that limits benefit duration; or
- 10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
  - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

GBD-1200 F18 (10/08)

**Family Care Credit Benefit:** *What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?*

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

- 1) Family Care means the care or supervision of:
  - a) Your children under age 13; or
  - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- 2) the maximum monthly deduction allowed for each qualifying child or family member is:
  - a) \$350 during the first 12 months of Rehabilitation; and
  - b) \$175 thereafter;

- but in no event may the deduction exceed the amount of Your monthly earnings;
- 3) Family Care Credits may not exceed a total of \$2,500 during a calendar year;
- 4) the deduction will be reduced proportionally for periods of less than a month;
- 5) the charges for Family Care must be documented by a receipt from the caregiver;
- 6) the credit will cease on the first to occur of the following:
  - a) You are no longer in a Rehabilitation program; or
  - b) Family Care Credits for 24 months have been deducted during Your Disability; and
- 7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.  
GBD-1200 F25 (10/08) (Rev-1)

**Survivor Income Benefit:** *Will my survivors receive a benefit if I die while receiving Disability Benefits?*

If You were receiving a Monthly Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

- 1) of Your death; and
- 2) that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

The Survivor Income Benefit will only be paid:

- 1) to Your Surviving Spouse; or
- 2) if no Surviving Spouse, in equal shares to Your Surviving Children.

If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

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

The Survivor Income Benefit amount is shown on the Schedule of Insurance.

**Surviving Spouse** means Your spouse who was not divorced from You when You died.

**Surviving Children** means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 19.

The term Surviving Children will also include any other children related to You by blood or marriage and who:

- 1) lived with You in a regular parent-child relationship; and
- 2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

GBD-1200 F27 (10/08) (Rev-1) (TX)

**Workplace Modification Benefit:** *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

- 1) Your Disability is covered by The Policy;
- 2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
- 3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such Workplace Modification shall not exceed \$25,000.

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

- 1) a Physician or other health care professional; or
- 2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

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

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

GBD-1200 F29 (10/08) (Rev-1)

## EXCLUSIONS AND LIMITATIONS

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

The Policy does not cover, and We will not pay a benefit for, any Disability:

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

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

- 1) was sponsored by Your Employer; and
- 2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

GBD-1200 G01 (10/08)

### **Pre-existing Condition Limitation:** *Are benefits limited for Pre-existing Conditions?*

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

- 1) You have not received Medical Care for the condition for 12 consecutive months while insured under The Policy; or
- 2) You have been continuously insured under The Policy for 24 consecutive months.

**Pre-existing Condition** means any disease or physical condition related to or resulting from accidental bodily injury or sickness for which You received Medical Care during the 12 consecutive month period that ends the day before:

- 1) Your effective date of coverage; or
- 2) the effective date of a Change in Coverage.

**Medical Care** is received when a Physician or other health care provider:

- 1) is consulted or gives medical advice; or
- 2) recommends, prescribes, or provides Treatment.

**Treatment** includes but is not limited to:

- 1) medical examinations, tests, attendance or observation; and
- 2) use of drugs, medicines, medical services, supplies or equipment.

GBD-1200 G04 (10/08) (Rev-2) (TX)

## GENERAL PROVISIONS

### **Notice of Claim:** *When should I notify the Company of a claim?*

You must give Us written notice of a claim within 30 days after Disability or loss occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address, and the Policy Number.

GBD-1200 H01 (10/08) (TX)

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

We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.  
GBD-1200 H02 (10/08)

**Proof of Loss:** *What is Proof of Loss?*

Proof of Loss may include but is not limited to the following:

- 1) documentation of:
  - a) the date Your Disability began;
  - b) the cause of Your Disability;
  - c) the prognosis of Your Disability;
  - d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
  - e) evidence that You are under the Regular Care of a Physician;
- 2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 3) the names and addresses of all:
  - a) Physicians or other qualified medical professionals You have consulted;
  - b) hospitals or other medical facilities in which You have been treated; and
  - c) pharmacies which have filled Your prescriptions within the past three years;
- 4) Your signed authorization for Us to obtain and release:
  - a) medical, employment and financial information; and
  - b) any other information We may reasonably require;
- 5) disclosure of all information and documentation required by Us relating to Other Income Benefits;
- 6) proof that You and Your dependents have applied for all Other Income Benefits which are available; and
- 7) disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

GBD-1200 H03 (10/08) (Rev-1)

**Additional Proof of Loss:** *What Additional Proof of Loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

- 1) meet and interview with Our representative; and
- 2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

- 1) at Our expense; and
- 2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

GBD-1200 H04 (10/08)

**Sending Proof of Loss:** *When must Proof of Loss be given?*

Written Proof of Loss must be sent to Us within 90 days following the completion of the Elimination Period. If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not reasonably possible to give proof within the required time; and
- 2) proof is given as soon as reasonably possible; but
- 3) not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, Our receipt of proof within 30 days of the request will allow Us to continue the ongoing adjudication of Your claim.

GBD-1200 H05 (10/08) (TX)

**Claim Payment:** *When are benefit payments issued?*

When We determine that You;

- 1) are Disabled; and
- 2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Benefits may be subject to interest payments as required by applicable law.  
GBD-1200 H06 (10/08)

**Claims to be Paid:** *To whom will benefits for my claim be paid?*

All payments are payable to You or Your assignee. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent;

then We may pay up to \$1,000 to a person who is Related to You. Any such payment shall fulfill Our responsibility for the amount paid.

GBD-1200 H08 (10/08) (TX) (Rev-1)

**Claim Denial:** *What notification will I receive if my claim is denied?*

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

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

GBD-1200 H09 (10/08) (TX)

**Claim Appeal:** *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

- 1) must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
  - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to Your claim; and
- 3) may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

GBD-1200 H10 (10/08) (TX)

**Social Security:** *When should I apply for Social Security Benefits?*

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

- 1) follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

GBD-1200 H11 (10/08) (TX)

**Plan Offered by a State or Municipal Government:** *When must I apply for benefits under a plan offered by a state or municipal government?*

You must apply for disability benefits under a plan offered by a state or municipal government, such as those offered by a public employee retirement system or state teacher retirement system, when the length of Your Disability meets the minimum duration required to apply for such benefits and You are eligible under the plan. You must apply within 45 days from the date of Our request. If the administrator of that alternative plan denies Your eligibility for benefits, You will be required to follow the process established by the administrator to reconsider the denial.

GBD-1200 H34 (10/08)

**Benefit Estimates:** *How does the Company estimate Disability benefits under the United States Social Security Act or an alternative plan offered by a state or municipal government?*

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, that You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits nor disability benefits under an alternative plan offered by a state or municipal government if:

- 1) You apply for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government if applicable, and pursue all required appeals in accordance with the Social Security and Plan Offered by a State or Municipal Government provisions; and
- 2) You have signed a form authorizing the Social Security Administration, or the administrator of the alternative plan offered by a state or municipal government if applicable, to release information about awards directly to Us; and
- 3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

- 1) You or Your dependent are later awarded Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
- 2) Your application for Social Security disability benefits, or disability benefits under an alternative plan offered by a state or municipal government, has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals, or similar level under an alternative plan offered by a state or municipal government when available.

If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits or disability benefits under an alternative plan offered by a state or municipal government were higher than We estimated, and if Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

GBD-1200 H12 (10/08) (Rev-1)

**Overpayment:** *When does an overpayment occur?*

An overpayment occurs:

- 1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
- 2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- 1) retroactive awards received from sources listed in the Other Income Benefits definition;
- 2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
- 3) misstatement;
- 4) fraud; or
- 5) any error We may make.

GBD-1200 H13 (10/08)

**Overpayment Recovery:** *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
  - a) You;
  - b) any other organization;
  - c) any other insurance company;
  - d) any other person to or for whom payment was made; and
  - e) Your estate;
- 2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- 3) refer Your unpaid balance to a collection agency; and

4) pursue and enforce all legal and equitable rights in court.  
GBD-1200 H14 (10/08)

**Subrogation:** *What are Our subrogation rights?*

If You:

- 1) suffer a Disability caused, in full or in part, by the act or omission of any person or legal entity;
- 2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
- 3) do not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that You do not intend to do so;

then We will be subrogated to any rights You may have against a Third Party and may bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Disability.

**Third Party** as used in this provision, means:

- 1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
- 2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

GBD-1200 H15 (10/08) (Rev-1) (TX)

**Reimbursement:** *What are Our reimbursement rights?*

We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:

- 1) a legal judgment;
- 2) an arbitration award; or
- 3) a settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:

- 1) the entire amount of the benefit payment(s) made or required to be made by Us; or
- 2) the total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds. We have the right of first reimbursement regardless of:

- 1) whether You are made whole;
- 2) how the recovered funds are characterized; or
- 3) whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:

- 1) agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and
- 2) will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

**Third Party** as used in this provision, means:

- 1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
- 2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

GBD-1200 H16 (10/08) (Rev-1)

**Legal Actions:** *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date Proof of Loss is given; or
- 2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

GBD-1200 H17 (10/08)

**Insurance Fraud:** *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter

and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

GBD-1200 H18 (10/08)

**Misstatements:** *What happens if facts are misstated?*

If material facts about You were not stated accurately:

- 1) Your premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

GBD-1200 H19 (10/08) (TX)

**Incontestability:** *When can coverage be contested?*

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

GBD-1200 H23 (10/08) (Rev-1) (TX)

**Eligibility Determination:** *How will We determine Your eligibility for benefits?*

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

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

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

GBD-1200 H25 (10/08) (TX)

**Physical Examinations and Autopsy:** *Will I be examined during the course of my claim?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as reasonably necessary; and
- 2) to make an autopsy in case of death where it is not forbidden by law.

GBD-1200 H21 (10/08)

**Assignment:** *Are there any rights of assignment?*

You have the right to absolutely assign Your rights and interest under The Policy. We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

You do not have the right to collaterally assign Your rights and interest under The Policy.

GBD-1200 H22 (10/08) (TX)



## DEFINITIONS

**Actively at Work** means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

GBD-1200 C01 (10/08)

**Active Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

GBD-1200 C03 (10/08)

**Any Occupation** means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

- 1) the product of Your Indexed Pre-disability Earnings and the Benefit Percentage; or
- 2) the Maximum Monthly Benefit.

GBD-1200 C05 (10/08) (Rev-1)

**Current Monthly Earnings** means monthly earnings You receive from:

- 1) Your Employer; and
- 2) other employment;

while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month period just before You became Disabled will count as Current Monthly Earnings.

Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:

- 1) such job was offered to You by Your Employer, or another employer, and You refused the offer; and
- 2) the requirements of the position were consistent with:
  - a) Your education, training and experience; and
  - b) Your capabilities as medically substantiated by Your Physician.

GBD-1200 C09 (10/08) (Rev-1)

**Disability or Disabled** means You are prevented from performing one or more of the Essential Duties of:

- 1) Your Occupation during the Elimination Period;
- 2) Your Occupation, for the 2 years following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
- 3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:

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

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.

GBD-1200 C15 (10/08) (Rev-1)

**Elimination Period** means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law.  
GBD-1200 C16 (10/08)

**Employer** means the Policyholder.  
GBD-1200 C17 (10/08)

**Essential Duty** means a duty that:

- 1) is substantial, not incidental;
- 2) is fundamental or inherent to the occupation; and
- 3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. However, working more than 45 hours per week is not an Essential Duty.  
GBD-1200 C18 (10/08) (Rev-1)

**Indexed Pre-disability Earnings** means Your Pre-disability Earnings adjusted annually by adding the lesser of:

- 1) 10%; or
- 2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.  
GBD-1200 C19 (10/08)

**Mental Illness** means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

- 1) Mental Retardation;
- 2) Pervasive Developmental Disorders;
- 3) Motor Skills Disorder;
- 4) Substance-Related Disorders;
- 5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- 6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

GBD-1200 C21 (10/08)

**Monthly Benefit** means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.  
GBD-1200 C22 (10/08)

**Monthly Income Loss** means Your Pre-disability Earnings minus Your Current Monthly Earnings.  
GBD-1200 C23 (10/08)

**Other Income Benefits** means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

- 1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- 2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
- 3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;

- 4) mandatory "no fault" automobile insurance plan;
- 5) disability benefits under:
  - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
  - b) the Railroad Retirement Act;
  - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
  - d) similar plan or act;
 that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
- 6) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
  - a) that begins after You become Disabled; or
  - b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

- 1) disability benefit under Your Employer's Retirement Plan;
- 2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- 3) portion of a judgment or settlement of a claim or lawsuit that represents or compensates for Your loss of earnings, less Our pro rata share of any associated reasonable attorneys' fees and court costs;
- 4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
  - a) You were receiving it prior to becoming Disabled; or
  - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;
 (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
- 5) retirement benefits under:
  - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
  - b) the Railroad Retirement Act;
  - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
  - d) similar plan or act;
 that You and Your spouse and children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

- 1) the amount attributed to loss of income; and
- 2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

- 1) takes effect after the date benefits become payable under The Policy; and
- 2) is a general increase which applies to all persons who are entitled to such benefits.

GBD-1200 C24 (10/08)

**Physician** means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Related to You by blood or marriage.

GBD-1200 C27 (10/08)

**Pre-disability Earnings** means Your regular monthly rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day You were Actively at Work before You became Disabled.

However, if You were an hourly paid Active Employee before You became Disabled, Pre-disability Earnings means the product of:

- 1) the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
- 2) Your hourly wage in effect immediately prior to the last day You were Actively at Work before You became Disabled.

GBD-1200 C29 (10/08)

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

GBD-1200 C34 (10/08) (Rev-1)

**Regular Care of a Physician** means that You are being treated by a Physician:

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

GBD-1200 C35 (10/08)

**Rehabilitation** means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

- 1) vocational testing;
- 2) vocational training;
- 3) alternative treatment plans such as:
  - a) support groups;
  - b) physical therapy;
  - c) occupational therapy; or
  - d) speech therapy;
- 4) work-place modification to the extent not otherwise provided;
- 5) job placement;
- 6) transitional work; and
- 7) similar services.

GBD-1200 C36 (10/08)

**Related** means Your spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

GBD-1200 C38 (10/08)

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

- 1) a profit sharing plan;
- 2) thrift, savings or stock ownership plans;
- 3) a non-qualified deferred compensation plan; or
- 4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

GBD-1200 C39 (10/08)

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

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

Substance includes alcohol and drugs but excludes tobacco and caffeine.

GBD-1200 C42 (10/08)

**The Policy** means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

GBD-1200 C43 (10/08)

**We, Our, or Us** means the insurance company named on the face page of The Policy.  
GBD-1200 C48 (10/08)

**Your Occupation** means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.  
GBD-1200 C49 (10/08)

**You or Your** means the person to whom this certificate is issued.  
GBD-1200 C50 (10/08)



# HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)

## NONINSURANCE BENEFITS AND SERVICES

### Benefits and Services

In addition to the Insurance coverage, We may offer noninsurance benefits and services to Eligible Persons. Eligible Persons should contact the Policyholder for more information on the services available on their plan.

Eligible Persons can obtain a description and contact information for noninsurance benefits and services by visiting [www.thehartfordatwork.com](http://www.thehartfordatwork.com).

The following benefits terminate upon policy termination:

- Will Preparation Services. These services provide access to an online tool to create a customized will with the help of licensed attorneys, if needed.
- Travel Assistance Related Services. These services provide help for situations that travelers may be facing like replacing a lost passport or arranging for local medical assistance.
- Identity Theft Related Services. These services provide fraud prevention and credit monitoring as well as resolution support if an Eligible Person is the victim of identity theft.
- Funeral Planning Services. These services provide support to Eligible Persons or their beneficiaries to prepare for a funeral with access to online planning and research tools and advisors to answer questions.

The following benefits terminate upon policy termination. If an Eligible Person is receiving benefits when the policy terminates, benefits may continue beyond the policy termination date.

- Employee Assistance Programs. Support is provided for a wide range of social and emotional issues. The program provides for either telephonic or face-to-face counseling sessions.
- Beneficiary Support Services. These services provide emotional, legal or financial guidance, answer benefit-related questions or provide referrals to Eligible Persons or their beneficiaries.

### Optional Enhanced Benefits and Services

The Policyholder may select optional enhanced noninsurance benefits and services for a nominal cost, ranging from \$.01 to \$4.50 monthly, depending on the level of service and the plan design selected. Eligible Persons should contact the Policyholder for more information on the optional services available and cost, if any.

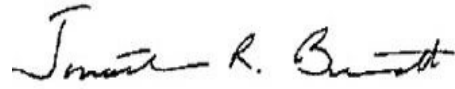
The noninsurance benefits and services provided are offered by third party vendors. While The Hartford has arranged these benefits and services, the third party providers are liable to the Eligible Persons for the provision of such benefits and services. The Hartford is not responsible for the provision of benefits and services nor is it liable for the failure of the provision of the same. Further, The Hartford is not liable to Eligible Persons for the negligent provisions of such benefits

and services by the third party providers. Note that The Hartford in its sole discretion may change vendors or may terminate any noninsurance benefit or service. The Eligible Persons will be given 60 days notice of such termination, unless, the termination is due to circumstances beyond The Hartford's control, such as a vendor terminating its services.

Signed for Hartford Life and Accident Insurance Company



Kevin Barnett, *Secretary*



Jonathan Bennett, *President*

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

### For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:**
  - Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is not protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, Texas 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 12030  
Austin, Texas 78711-2030  
1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



**ERISA INFORMATION  
THE FOLLOWING NOTICE  
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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**1. Plan Name**

For employees of :

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**2. Plan Number**

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**3. Employer/Plan Sponsor**

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**4. Employer Identification Number**

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**5. Type of Plan**

Welfare Benefit Plan providing:

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**6. Plan Administrator**

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**7. Agent for Service of Legal Process**

For the Plan

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For the Policy:

Hartford Life and Accident Insurance Company  
One Hartford Plaza  
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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**8. Sources of Contributions**

**(Group Long Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
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10. The Plan and its records are kept on a Year basis.
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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

### 1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### 2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### 4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

### Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

### **Claim Procedures for Claims Not Requiring a Determination of Disability**

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

#### **Claims for Benefits**

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

#### **Appealing Denials of Claims for Benefits**

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

#### **Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

#### **Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

#### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**Maryland**

**The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**



## State Notices

**IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:** There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at [www.thehartford.com](http://www.thehartford.com). If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

**The Hartford**  
**Group Benefits Division, Customer Service**  
**P.O. Box 2999**  
**Hartford, CT 06104-2999**  
**1-800-523-2233**  
<https://www.thehartford.com/>

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

### **Alaska:**

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

### **Arizona:**

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

### **Arkansas:**

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:  
Arkansas Insurance Department  
1 Commerce Way, Suite 102  
Little Rock, AR 72202

### **California:**

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

**Eligibility Determination:** *How will We determine Your or Your Dependent's eligibility for benefits?*

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

- 1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;
- 2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
- 3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
- 4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

## 2. For Your Questions and Complaints:

State of California Insurance Department  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
**Toll Free:** 1(800) 927-HELP  
**TDD Number:** 1(800) 482-4833  
**Web Address:** [www.insurance.ca.gov](http://www.insurance.ca.gov)

### Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
5. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

### Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.
2. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

### Georgia:

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

**Idaho:**

1. **For Your Questions and Complaints:**  
Idaho Department of Insurance  
Consumer Affairs  
700 W State Street, 3rd Floor  
PO Box 83720  
Boise, ID 83720-0043  
**Toll Free:** 1-800-721-3272  
**Web Address:** [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

**Illinois:**

1. **For Your Questions and Complaints:**  
Illinois Department of Insurance  
Consumer Services Station  
Springfield, Illinois 62767  
**Consumer Assistance:** 1(866) 445-5364  
**Officer of Consumer Health Insurance:** 1(877) 527-9431  
**Web Address:** <http://insurance.illinois.gov/>
2. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

**STATE OF ILLINOIS**  
**The Religious Freedom Protection and Civil Union Act**  
**Effective June 1, 2011**

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at <http://insurance.illinois.gov/>.

**Indiana:**

1. **For Your Questions and Complaints:**  
Public Information/Market Conduct  
Indiana Department of Insurance  
311 W. Washington St. Suite 300  
Indianapolis, IN 46204-2787  
1(317) 232-2395

**Louisiana:**

1. The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21, if less than 21.
2. The following requirement applies to you:

**Reinstatement after Military Service:** *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage ended;
- 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and

- 3) be subject to all the terms and provisions of The Policy.

**Maine:**

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

**Massachusetts:**

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website ([www.mahealthconnector.org](http://www.mahealthconnector.org)).**

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

**If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at [www.mass.gov/doi](http://www.mass.gov/doi).**

**Michigan:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

**Minnesota:**

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions**.
2. If there are 25 or more residents of Minnesota who are covered under The Policy, or there are fewer than 25 residents and those residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

**Minnesota Coverage Continuation:** If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:

- 1) the date Your coverage would otherwise terminate; or
- 2) the date You receive a written notice of Your right to continue coverage from the Employer;

whichever is later.

The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:

- 1) Your right to continue coverage;
- 2) the amount of premium; and
- 3) how, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:

- 1) the date You are covered under another group policy;
- 2) the date the required premium is due but not paid; or
- 3) the last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:

- 1) exercise Your Conversion Right; or
- 2) continue coverage under a group Portability policy; and

- 3) qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit

4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

#### Missouri:

1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180 days.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

#### Montana:

1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

#### New Hampshire:

1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

**Spouse Continuation:** *Can coverage for my Spouse be continued in the event of divorce or separation?*  
If:

- 1) You are a resident of New Hampshire;
- 2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
- 3) the final decree of divorce or legal separation does not expressly prohibit it;

Your former Spouse may continue his or her coverage.

We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

- 1) the 3-year anniversary of the final decree of divorce or legal separation;
- 2) the remarriage of the former Spouse;
- 3) Your death;
- 4) an earlier time as provided by the final decree of divorce or legal separation; or
- 5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

#### New Mexico:

1. **For Your Questions and Complaints:**  
Office of Superintendent of Insurance  
Consumer Assistance Bureau  
P.O. Box 1689

**New York:**

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
  - 1) you are both legally and mentally competent to consent to contract in the state in which you reside;
  - 2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
  - 3) you have been living together on a continuous basis prior to the date of the application;
  - 4) neither of you have been registered as a member of another domestic partnership within the last six months; and
  - 5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

- 1) a joint bank account;
- 2) a joint credit card or charge card;
- 3) joint obligation on a loan;
- 4) status as an authorized signatory on the partner's bank account, credit card or charge card;
- 5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
- 6) listing of both partners as tenants on the lease of the shared residence;
- 7) shared rental payments of residence (need not be shared 50/50)
- 8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- 9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
- 10) shared household budget for purposes of receiving government benefits;
- 11) status of one as representative payee for the other's government benefits;
- 12) joint responsibility for child care (e.g., school documents, guardianship);
- 13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
- 14) execution of wills naming each other as executor and/or beneficiary;
- 15) designation as beneficiary under the other's life insurance policy;
- 16) designation as beneficiary under the other's retirement benefits account;
- 17) mutual grant of durable power of attorney;
- 18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- 19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
- 20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

**North Carolina:**

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
  - 1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
  - 2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE

COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

### IMPORTANT TERMINATION INFORMATION

**YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.**

**THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.**

#### North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

#### Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

#### Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

#### Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

#### South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to \$2,000, if greater than \$2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

**South Dakota:**

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

**Texas:**

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **NOTICE:**

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

**Hartford Life and Accident Insurance Company**

To get information or file a complaint with your insurance company:

**Call: Customer Service at 860-547-5000**

**Toll-free: 1-800-523-2233**

Online: <https://www.thehartford.com/contact-the-hartford>

Email: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

**Call with a question: 1-800-252-3439**

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

**Hartford Life and Accident Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros:

**Llame a: servicio al cliente al 860-547-5000**

**Teléfono gratuito: 1-800-523-2233**

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: [GBD.Customerservice@hartfordlife.com](mailto:GBD.Customerservice@hartfordlife.com)

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:



Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

**Utah:**

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

**Vermont:**

1. The following requirement applies:

**Purpose:** This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

**General Definitions, Terms, Conditions and Provisions:** The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

- 1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
- 2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
- 3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
- 4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.
- 5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

**Cautionary Disclosure:** THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

**Virginia:**

1. **For Your Questions and Complaints:**  
**State Corporation Commission**  
**Life and Health Division**  
**Bureau of Insurance**  
P.O. Box 1157  
Richmond, VA 23218  
1(804) 371-9691 (inside Virginia)

**Washington:**

1. The following **Disputed Diagnosis** requirement applies to You:

**Disputed Diagnosis:** *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*

If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

**Wisconsin:**

1. **For Your Questions and Complaints:**

To request a Complaint Form:

Office of the Commissioner of Insurance

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

1(800) 236-8517 (outside of Madison)

1(608) 266-0103 (in Madison)

**Group Term Life Insurance**



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**One Hartford Plaza**

**Hartford, Connecticut 06155**

**(A stock insurance company)**

**The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.**

**CERTIFICATE OF INSURANCE**

**Policyholder:** City of Victoria

**Policy Number:** GL-891798

**Policy Effective Date:** January 1, 2024

**Policy Anniversary Date:** January 1

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, Secretary

Jonathan Bennett, President

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*A note on capitalization in this Certificate:*

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

Insured: \_\_\_\_\_

Amount of Insurance: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

**Death benefits will be reduced if an Accelerated Benefit is paid.**

**DISCLOSURE:** The acceleration-of-life insurance benefits offered under this certificate may or may not qualify for favorable tax treatment under the Internal Revenue Code. Whether such benefits qualify depends on factors such as the Covered Person's life expectancy at the time benefits are accelerated or whether the Covered Person uses the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life insurance benefits qualify for favorable tax treatment, the benefits will be excludable from the Covered Person's income and not subject to federal taxation. Tax laws relating to acceleration-of-life insurance benefits are complex. The Covered Person is advised

to consult with a qualified tax advisor about circumstances under which the Covered Person could receive acceleration-of-life insurance benefits excludable from income under federal law.

**DISCLOSURE:** Receipt of acceleration-of-life insurance benefits may affect the Covered Person's spouse, or the Covered Person's family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid of Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. The Covered Person is advised to consult with a qualified tax advisor and with social security service agencies concerning how receipt of such payment will affect the Covered Person's, the Covered Person's spouse's, or the Covered Person's family's eligibility for public assistance.

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GBD-1100 A01 (10/08)	

## SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of: **October 1, 2024**

**Cost of coverage:**

**Non-Contributory Coverage:**

Basic Life Insurance  
Basic Accidental Death and Dismemberment  
Supplemental Dependent Life Insurance

**Contributory Coverage:**

Supplemental Life Insurance  
Supplemental Accidental Death and Dismemberment

**Disclosure of Payment to the Policyholder:**

We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:

- 1) audit;
- 2) marketing communication services; and
- 3) other administrative expenses.

**Eligible Class(es) For Coverage:** All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least 30 hours weekly

**Annual Enrollment Period:** as determined by Your Employer on a yearly basis.

**Eligibility Waiting Period for Coverage:**

- 1) None - if You are working for the Employer on the Policy Effective Date; or
- 2) The first day of the month following 30 day(s) of employment - if You start working for the Employer after the Policy Effective Date.

The time period(s) referenced above is continuous.

### Life Insurance Benefit

Basic Amount of Life Insurance:

**Maximum Amount**

1 times Your annual Earnings, subject to a maximum of \$100,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Basic Amount of Life Insurance be less than \$10,000 before any reductions in coverage due to age apply.

Supplemental Amount of Life Insurance

**Guaranteed Issue Amount**

\$300,000

**Maximum Amount**

1, 2 or 3 times Your annual Earnings, subject to a maximum of \$500,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Supplemental Amount of Life Insurance be less than \$10,000.

### Dependent Life Insurance Benefit

### Supplemental Amount of Dependent Life Insurance

	<b>Guaranteed Issue Amount</b>	<b>Maximum Amount</b>
Spouse	The amount You elect in increments of \$5,000, subject to a minimum of \$5,000 and a maximum of \$50,000.	The amount You elect in increments of \$5,000, subject to a minimum of \$5,000 and a maximum of \$250,000.
Dependent Children: live birth but under age 25 year(s)		The amount You elect in increments of \$5,000, subject to a minimum of \$5,000 and a maximum of \$10,000.

The amount of Spouse Supplemental coverage may never exceed 100% of the Supplemental Amount of Life Insurance in force for the employee.

### Accidental Death and Dismemberment Benefit

#### Basic Principal Sum

##### **Maximum Amount**

1 times Your annual Earnings, subject to a maximum of \$100,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Basic Principal Sum be less than \$10,000 before any reductions in coverage due to age apply.

#### Supplemental Principal Sum

##### **Maximum Amount**

1, 2 or 3 times Your annual Earnings, subject to a maximum of \$500,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Supplemental Principal Sum be less than \$10,000.

### Dependent Accidental Death and Dismemberment Benefit

#### Supplemental Principal Sum

##### **Maximum Amount**

Spouse	The amount You elect in increments of \$5,000, subject to a minimum of \$5,000 and a maximum of \$250,000.
Dependent Children: live birth but under age 25 year(s)	The amount You elect in increments of \$5,000, subject to a minimum of \$5,000 and a maximum of \$10,000.

### **Reduction in Amount of Life Insurance**

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

- 1) in accordance with the Conversion Right;
- 2) under the Portability Provision; or
- 3) under the Prior Policy.

### **Reduction in Coverage Due to Age**

We will reduce the Life Insurance Benefit and Principal Sum for You and Your Spouse by the percentage indicated in the table below. This reduction will be effective on the Policy Anniversary Date You attain the ages shown below. The reduction will apply to the Amount of Life Insurance and Principal Sum in force immediately prior the first reduction made.

These reductions also apply if:

- 1) You or Your Spouse become covered under The Policy; or
- 2) Your or Your Spouse's coverage increases;

on or after the date You attain age 70.

Percentage by which original amount of coverage will be reduced.	Your Age	Your % Reduction	Your Spouse's % Reduction
	70	35%	35%
	75	50%	50%

The reduced amount of coverage will be rounded to the next higher multiple of \$1000, if not already a multiple of \$1000. An appropriate adjustment in premium will be made.

### **Additional Accidental Death and Dismemberment Benefits**

#### **Seat Belt Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 10%

Maximum Amount: \$10,000

Minimum Amount: \$1,000

#### **Air Bag Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

#### **Repatriation Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

#### **Child Education Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

Minimum Amount: \$1,250

#### **Day Care Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

Minimum Amount: \$1,250

#### **Rehabilitation Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

#### **Spouse Education Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

Minimum Amount: \$1,250

#### **Adaptive Home and Vehicle Benefit**

Percentage of Accidental Death and Dismemberment Principal Sum: 5%

Maximum Amount: \$5,000

GBD-1100 B02 (10/08) (Rev-1) (TX)



## ELIGIBILITY AND ENROLLMENT

### **Eligible Persons:** *Who is eligible for coverage?*

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

GBD-1100 D01 (10/08)

### **Eligibility for Coverage:** *When will I become eligible?*

You will become eligible for coverage on the later of:

- 1) the Policy Effective Date;
- 2) the date You become a member of an Eligible Class; or
- 3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

GBD-1100 D02 (10/08)

### **Eligibility for Dependent Coverage:** *When will I become eligible for Dependent Coverage?*

You will become eligible for Dependent coverage on the later of:

- 1) the date You become insured for employee coverage; or
- 2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as an Active Employee under The Policy.

No person can be insured as a Dependent of more than one employee under The Policy.

GBD-1100 D03 (10/08) (Rev-1)

### **Enrollment:** *How do I enroll for coverage?*

For Non-Contributory Coverage, Your Employer will automatically enroll You and Your Dependents. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:

- 1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your coverage; and
- 2) deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

If You do not enroll for Your coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your coverage only:

- 1) during an Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

GBD-1100 D04 (10/08) (Rev-2)

### **Evidence of Insurability Requirements:** *When will I first be required to provide Evidence of Insurability?*

We require Evidence of Insurability for initial coverage, if You:

- 1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
- 2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- 3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

- 1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- 2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

GBD-1100 D05 (10/08) (Rev-1)

### **Dependent Evidence of Insurability Requirements:** *When will my Dependents first be required to provide Evidence of Insurability?*

We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

- 1) enroll for an Amount of Supplemental Dependent Life Insurance greater than the Supplemental Dependents' Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- 2) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is \$15,000 or less.

GBD-1100 D06 (10/08)

**Evidence of Insurability:** *What is Evidence of Insurability?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us;
- 2) a medical examination, if requested;
- 3) an attending Physicians' statement, if requested; and
- 4) any additional information We may require.

Evidence of Insurability will be furnished at Your expense. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

GBD-1100 D07 (10/08)

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

A Change in Family Status occurs when:

- 1) You get married;
- 2) You and Your spouse divorce;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse dies;
- 5) Your child dies;
- 6) Your spouse is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

GBD-1100 D08 (10/08)

## PERIOD OF COVERAGE

**Effective Date:** *When does my coverage start?*

Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

- 1) the date You become eligible, if You enroll on or before that date;
- 2) the Policy Anniversary Date on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 3) the date You enroll, if You do so within 31 days from the date You are eligible.

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

- 1) the date You become eligible; or
- 2) the date We approve Your Evidence of Insurability.

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

GBD-1100 E01 (10/08)

**Deferred Effective Date:** *When will my effective date for coverage or a change in my coverage be deferred?*

If, on the date You are to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

GBD-1100 E03 (10/08)

**Continuity from a Prior Policy:** *Is there continuity of coverage from a Prior Policy?*

Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were:

- 1) insured under the Prior Policy; and
- 2) Actively at Work;

but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance and accidental death and dismemberment principal sum:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after the Policy Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- 4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

GBD-1100 E05 (10/08) (Rev-1)

**Dependent Effective Date:** *When does Dependent coverage start?*

Non-Contributory Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

GBD-1100 E07 (10/08)

**Dependent Deferred Effective Date:** *When will the effective date for Dependent coverage or a change in coverage be deferred?*

If, on the date Your Dependent, other than a newborn, is to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit; and

he or she is:

- 1) confined in a hospital; or
- 2) Confined Elsewhere

such coverage will not start until he or she:

- 1) is discharged from the hospital; or
- 2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Child(ren).

**Confined Elsewhere** means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

GBD-1100 E09 (10/08)

**Dependent Continuity from a Prior Policy:** *Is there continuity of coverage from a Prior Policy for my Dependents?*

If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance and Accidental Death and Dismemberment Principal Sum will be the lesser of the amount of life insurance and accidental death and dismemberment principle sum:

- 1) Your Dependents had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

GBD-1100 E11 (10/08)

**Change in Coverage:** *When may I change my coverage?*

After Your initial enrollment You may increase or decrease coverage:

- 1) during any Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date of a Change in Family Status.

GBD-1100 E12 (10/08) (Rev-1)

**Effective Date for Changes in Coverage:** *When will changes in coverage become effective?*

Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

- 1) the date of the change;
- 2) the date requirements of the Deferred Effective Date provision are met;
- 3) the date Evidence of Insurability is approved, if required; or
- 4) the Policy Anniversary Date on or next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

GBD-1100 E13 (10/08) (Rev-1)

**Increase in Amount of Life Insurance:** *If I request an increase in the Amount of Life Insurance for myself or my Dependents, must we provide Evidence of Insurability?*

If You or Your Dependents are:

- 1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for any increase; or
- 2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Supplemental Life Insurance coverage; including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance he or she had in effect on the date immediately prior to the date You requested the increase will not change.

GBD-1100 E15 (10/08) (Rev-2)

**Increase in Amount of Life Insurance:** *If my Amount of Life Insurance increases because my Earnings increase, must I provide Evidence of Insurability?*

If Your Amount of Life Insurance is based on a multiple of Your Earnings, You must provide Evidence of Insurability if Your Earnings increase such that Your Amount of Life Insurance is greater than the Guaranteed Issue Amount. An increase in Earnings which causes an increase in Your Amount of Life Insurance will be accompanied by a corresponding increase in the amount of premium due for this coverage.

Once approved, We will not require Evidence of Insurability again if Your Amount of Life Insurance increases solely because Your Earnings increased.

However, if:

- 1) You do not submit Evidence of Insurability; or
- 2) Your Evidence of Insurability is not satisfactory to Us,

Your Amount of Life Insurance:

- 1) will increase, but only up to the amount for which You were eligible without having to provide Evidence of Insurability; and
- 2) will not increase again, or beyond that amount, until Your Evidence of Insurability is approved.

GBD-1100 E16 (10/08) (Rev-1)

**Termination:** *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
- 3) the date the premium payment is due but not paid;
- 4) the date Your Employer terminates Your employment; or
- 5) the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

GBD-1100 E17 (10/08)

**Dependent Termination:** *When does coverage for my Dependent end?*

Coverage for Your Dependent will end on the earliest to occur of:

- 1) the date Your coverage ends;
- 2) the date the required premium is due but not paid;
- 3) the date You are no longer eligible for Dependent coverage;
- 4) the date We or the Employer terminate Dependent coverage; or
- 5) the date the Dependent no longer meets the definition of Dependent,

unless continued in accordance with the Continuation Provisions.

GBD-1100 E21 (10/08)

**Continuation Provisions:** *Can my coverage and my Dependent's coverage be continued beyond the date it would otherwise terminate?*

Coverage under The Policy may be continued, at Your Employer's option, beyond a date shown in the Termination provision, provided Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium;
- 3) may be continued up to the maximum time shown in the provisions; and
- 4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

In no event will coverage under the following Continuation Provisions, when combined, extend longer than 12 months from the date You were last Actively at Work: Leave of Absence, Military Leave of Absence, Lay Off, Disability Insurance, Sickness or Injury or Family Medical Leave.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 3 months after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You or Your Dependent enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 12 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Employer due to lack of work, all of Your coverage (including Dependent Life coverage) may be continued for 3 months after the month in which the lay off commenced. If the lay off becomes permanent, this continuation will cease immediately.

Disability Insurance: If You are working for the Policyholder and:

- 1) are covered by;
- 2) are receiving benefits under;
- 3) meet the definition of disabled under; and
- 4) are earning at least 20%, but less than 80%, of Your pre-disability earnings, as defined by;

a group long term disability insurance policy, issued by Us to Your Employer, Your coverage (including Dependent Life coverage) may be continued for a period of 6 consecutive months from the date You were last Actively at Work while You remain disabled.

**Sickness or Injury:** If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:

- 1) for a period of 6 consecutive months from the date You were last Actively at Work; or
- 2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 6 consecutive months.

**Family and Medical Leave:** If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

GBD-1100 E23 (10/08) (TX) (Rev-2)

**Continuation for Dependent Child(ren) with Disabilities:** *Will coverage for Dependent Child(ren) with Disabilities be continued?*

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- 1) age 26 or older; and
- 2) disabled; and
- 3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

- 1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
- 2) such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

- 1) You remain insured;
- 2) the child continues to meet the required conditions; and
- 3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

GBD-1100 E26 (10/08) (TX)

**Waiver of Premium:** *Does coverage continue if I am Disabled?*

Waiver of Premium is a provision which allows You to continue Your and Your Dependents' coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:

- 1) will be the amount in force on the date You cease to be an Active Employee;
- 2) will be subject to any reductions provided by The Policy; and
- 3) will not increase.

Only Your Dependents who were covered under The Policy when You were last Actively at Work will be covered under Waiver of Premium.

GBD-1100 E27 (10/08)

**Eligible Coverages:** *What coverages are eligible under this provision?*

This provision applies only to:

- 1) Your Basic Life Insurance;
- 2) Your Supplemental Life Insurance; and
- 3) Dependent Life Insurance.

GBD-1100 E31 (10/08) (Rev-1)

**Disabled:** *What does Disabled mean?*

Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:

- 1) education;
- 2) training; or
- 3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 12 months or less.  
GBD-1100 E32 (10/08)

**Conditions for Qualification:** *What conditions must I satisfy before I qualify for this provision?*

To qualify for Waiver of Premium You must:

- 1) be covered under The Policy and be under age 60 when you become Disabled;
- 2) be Disabled and provide Proof of Loss that You have been Disabled for 6 consecutive months, starting on the date You were last Actively at Work or provide proof that You have been diagnosed with a life expectancy of 12 months or less; and
- 3) provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

GBD-1100 E34 (10/08) (Rev-1)

**When Premiums are Waived:** *When will premiums be waived?*

If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 6 months You are Disabled. We have the right to:

- 1) require Proof of Loss that You are Disabled; and
- 2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right for You and Your Dependents.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 6 months that You are Disabled, the 6 month waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 6 month period. If You return to work for more than 5 days, You must satisfy a new waiting period.

GBD-1100 E36 (10/08)

**Benefit Payable before Approval of Waiver of Premium:** *What if I die or my Dependent dies before I qualify for Waiver of Premium?*

If You or Your Dependent die within one year of Your last day of work as an Active Employee, but before You qualify for Waiver of Premium, We will pay the Amount of Life Insurance which is in force for the deceased person provided:

- 1) You were continuously Disabled;
- 2) the Disability lasted or would have lasted 6 month(s) or more; and
- 3) premiums had been paid for coverage.

GBD-1100 E37 (10/08)

**Waiver Ceases:** *When will Waiver of Premium cease?*

We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain age 65.

We will waive premium payments for Your Dependent Life Insurance and continue such coverage, while You remain Disabled, until the earliest of the date:

- 1) You die;
- 2) You no longer qualify for Waiver of Premium;
- 3) The Policy terminates;
- 4) Your Dependents are no longer in an Eligible Class, or Dependent coverage is no longer offered; or
- 5) Your Dependent no longer meets the definition of Dependent.

**What happens when Waiver of Premium ceases?**

When the Waiver of Premium ceases:

- 1) if You return to work in an Eligible Class, as an Active Employee, then You may again be eligible for coverage for Yourself and Your Dependents as long as premiums are paid when due; or
- 2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right for You and Your Dependents if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

**Effect of Policy Termination:** *What happens to the Waiver of Premium if The Policy terminates?*

If The Policy terminates before You qualify for Waiver of Premium:

- 1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
- 2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium:

- 1) Your Dependent coverage will terminate; and
- 2) Your coverage under the terms of this provision will not be affected.

GBD-1100 E41 (10/08) (TX) (Rev-1)

## BENEFITS

**Life Insurance Benefit:** *When is the Life Insurance Benefit payable?*

If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

GBD-1100 F01 (10/08)

**Suicide:** *What benefit is payable if death is a result of suicide?*

If You or Your Dependent commit suicide while sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

Any premium paid by You during this 2 year period for initial amounts of Supplemental Life Insurance or elected increases in Supplemental Life Insurance, will be returned to Your beneficiary.

GBD-1100 F03 (10/08)

**Accidental Death and Dismemberment Benefit:** *When is the Accidental Death and Dismemberment Benefit payable?*

If You or Your Dependents sustain an Injury which results in any of the following Losses within 365 days of the date of accident, and the accident occurs while You are covered under this benefit, We will pay the injured person's amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss after We receive Proof of Loss in accordance with the Proof of Loss provision.

This benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance. The amount of Your Dependents' Principal Sum is shown in the Schedule of Insurance.

PA-9223 F07 (10/08)

**For Loss of:**

**Benefit:**

Life.....	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes.....	Principal Sum
One Hand and One Foot.....	Principal Sum
Speech and Hearing in Both Ears.....	Principal Sum
Either Hand or Foot and Sight of One Eye.....	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia) .....	Principal Sum
Movement of Four Entire Limbs.....	Principal Sum
Movement of Both Lower Limbs (Paraplegia).....	Three-Quarters of Principal Sum
Movement of Three Entire Limbs.....	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia) .....	Three-Quarters of Principal Sum
Movement of Two Entire Limbs.....	Two-Thirds of Principal Sum
Movement of One Entire Limb.....	One-Half of Principal Sum



#### Movement of the Upper And Lower Limbs

of One Side of the Body (Hemiplegia).....	One-Half of Principal Sum
Either Hand or Foot.....	One-Half of Principal Sum
Sight of One Eye.....	One-Half of Principal Sum
Speech or Hearing in Both Ears. ....	One-Half of Principal Sum
Movement of One Limb (Uniplegia).....	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand .....	One-Quarter of Principal Sum

PA-9223 F12 (10/08)

#### **Loss** means with regard to:

- 1) hands and feet, actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing, entire and irrecoverable loss thereof;
- 3) thumb and index finger, actual severance through or above the metacarpophalangeal joints;
- 4) movement, complete and irreversible paralysis of such limbs; or
- 5) movement, complete, permanent and irreversible paralysis, as determined by a Physician, of an Entire Limb or Limbs which has continued without interruption for a period of not less than 12 consecutive months.

#### **Entire Limb** means with regard to:

- 1) the arm, the total areas from shoulder joint to finger tips;
- 2) the leg, the total area from hip joint to toes.

PA-9223 F13 (10/08)

#### **Exposure and Disappearance:** *What if Loss is due to exposure or disappearance?*

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

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

We will presume that You or Your Dependents suffered Loss of life if:

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

PA-9223 F15 (10/08)

#### **Seat Belt and Air Bag Benefit:** *When is the Seat Belt and Air Bag Benefit payable?*

If You or Your Dependents sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while the injured person was:

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

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

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if the injured person was:

- 1) positioned in a seat equipped with a factory-installed Air Bag; and
- 2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

- 1) an amount resulting from multiplying the injured person's amount of Principal Sum by the Seat Belt Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:

- 1) an amount resulting from multiplying the injured person's amount of Principal Sum by the Air Bag Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

If it cannot be determined that the injured person was wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

**Accident**, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which the injured person was wearing a Seat Belt.

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

**Seat Belt** means:

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

The Seat Belt and Air Bag Benefit will not be payable if the injured person was operating the Motor Vehicle at the time of Injury while:

- 1) Intoxicated; or
- 2) taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

**Intoxicated** means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the laws of the state where the accident occurred. If the accident occurred outside the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F16 (10/08) (Rev-1)

**Repatriation Benefit: *When is the Repatriation Benefit payable?***

If You or Your Dependents sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of the deceased person's place of permanent residence. We will only pay a benefit if the deceased person's body is transported across state lines or country borders.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:

- 1) the actual expenses incurred for:
  - a) preparation of the body for burial or cremation; and
  - b) transportation of the body to the place of burial or cremation;
- 2) the amount resulting from multiplying the deceased person's amount of Principal Sum by the Repatriation Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F18 (10/08)

**Child Education Benefit: *When is the Child Education Benefit payable?***

If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Child Education Benefit to Your Dependent Child(ren).

This Benefit will be paid:

- 1) after We receive proof that Your Dependent Child(ren) qualify as a Student, as defined in this Benefit; and
- 2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Principal Sum by the Child Education Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Dependent Child(ren):

- 1) on the date; and
- 2) for whom;

We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:

- 1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
- 2) the end of the 12th consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

- 1) a Principal Sum is payable because of Your death; and
- 2) no person qualifies as a Student.

**Student** means Your Dependent Child(ren) who is covered on the date of Your death and:

- 1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
- 2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

The term Child(ren) also includes an unmarried grandchild who You claim as a Dependent for federal income tax purposes and a child age 25 and over who is physically or mentally disabled and living with you.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F20 (10/08) (TX)

**Day Care Benefit: *When is the Day Care Benefit payable?***

If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Day Care Benefit for each of Your Dependent Children if such Dependent Child is under age 7 at the time of Your death.

This Benefit will be paid:

- 1) after We receive proof of enrollment in a Day Care Program as described in this Benefit; and
- 2) according to the General Provisions of The Policy.

We will make one Day Care Benefit payment each year, for a maximum of 4 Day Care Benefit payments, for each Dependent Child. The Benefit will be paid to the person who has primary responsibility for the Dependent Child's Day Care expenses.

Proof of enrollment satisfactory to Us for each Dependent Child in a Day Care Program includes, but will not be limited to, the following:

- 1) a copy of the Dependent Child's approved enrollment application in a Day Care Program;
- 2) cancelled check(s) evidencing payment to a Day Care facility or Day Care provider;
- 3) a letter from the Day Care facility or Day Care provider stating that the Dependent Child:
  - a) is attending a Day Care Program; or

b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the death. Proof of enrollment must be sent to Us prior to the last day of the 12th month following the date of death.

If You die, the Day Care Benefit provides an annual amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Principal Sum by the Day Care Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision for payment of benefits for Loss of life if:

- 1) a Principal Sum is payable because of Your death; and
- 2) no person qualifies as a Dependent Child eligible for the Day Care Benefit.

**Day Care or Day Care Program** means a program of child care which:

- 1) is operated in a private home, school or other facility;
- 2) provides, and makes a charge for, the care of children; and
- 3) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or
- 4) if licensing is not required, provides childcare on a daily basis for 12 months a year.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F21 (10/08) (TX)

**Rehabilitation Benefit:** *When is the Rehabilitation Benefit payable?*

If You sustain an Injury which results in a Loss other than Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Rehabilitation Benefit for Rehabilitative Program Expenses Incurred within one (1) year of the date of accident.

This Benefit will be paid:

- 1) after We receive proof of Expenses Incurred for a Rehabilitative Program, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Rehabilitation Benefit provides an amount equal to the least of:

- 1) the actual Expense Incurred for a Rehabilitative Program;
- 2) the amount resulting from multiplying Your amount of Principal Sum by the Rehabilitation Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

**Rehabilitative Program** means any training which:

- 1) is required due to Your Injury; and
- 2) prepares You for an occupation for which You were not previously trained.

**Expense Incurred** means the actual cost of:

- 1) training; and
- 2) materials needed for the training.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F22 (10/08)

**Spouse Education Benefit:** *When is the Spouse Education Benefit payable?*

If You sustain an Injury that results in a Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Spouse Education Benefit to Your surviving Spouse.

This Benefit will be paid:

- 1) after We receive proof satisfactory to Us that the Spouse has enrolled in an Occupational Training program; and
- 2) according to the General Provisions of The Policy.

The Spouse Education Benefit is the least of;

- 1) the Expense Incurred for Occupational Training;
- 2) the amount resulting from multiplying Your Principal Sum by the Spouse Education Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

- 1) for the purpose of obtaining an independent source of income; and
- 2) within one (1) year of Your death.

**Occupational Training** means any:

- 1) educational;
- 2) professional; or
- 3) trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

**Expense Incurred** means:

- 1) the actual tuition charged, exclusive of room and board; and
- 2) the actual cost of the materials needed;

for the Occupational Training.

The expense must be incurred within two (2) years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F23 (10/08)

**Adaptive Home and Vehicle Benefit:** *When is the Adaptive Home and Vehicle Benefit payable?*

If You sustain an Injury that results in a Loss, other than Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Adaptive Home and Vehicle Benefit.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Adaptive Home and Vehicle Benefit pays a benefit for the one-time cost of alterations to Your:

- 1) principal residence; and/or
- 2) private automobile;

to make the residence accessible and/or the private automobile drivable or rideable for You. The costs must be incurred within two years from the date of accident.

We will pay the Adaptive Home and Vehicle Benefit if:

- 1) such home alterations are:
  - a) made by a person or persons with experience in such alterations; and
  - b) recommended by a recognized organization associated with the Injury; and/or
- 2) such vehicle modifications are:
  - a) carried out by a person or persons with experience in such matters; and
  - b) approved by the Motor Vehicle Department.

The Adaptive Home and Vehicle Benefit will provide an amount equal to the least of:

- 1) the actual cost of the alterations;
- 2) the amount resulting from multiplying Your amount of Principal Sum by the Adaptive Home and Vehicle Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F24 (10/08)

**Accelerated Benefit:** *What is the benefit? This benefit is not available for Dependents.*

In the event that You are diagnosed as Terminally Ill, while You are:

- 1) covered under The Policy for an Amount of Life Insurance of at least \$10,000; and
- 2) under age 60;

We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of Your Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required will be based on the amount of Your life insurance remaining after the Accelerated Benefit is paid under this benefit. There will be no effect on the Accidental Death and Dismemberment Benefit Principal Sum after the Accelerated Benefit Amount is paid under this benefit.

You may request a minimum Accelerated Benefit amount of \$3,000 and a maximum of \$500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your Amount of Life Insurance. This option may be exercised only once.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of \$100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from \$10,000 to \$80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only \$30,000 now, You cannot request the additional \$50,000 in the future.

If You submit proof satisfactory to Us of Your Terminal Illness You will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

You will receive a statement specifying the benefit paid and the remaining Life Insurance Benefit.

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Amount of Life Insurance as used in this benefit means Basic and Supplemental Life Insurance.

**Terminal Illness or Terminally Ill** means a life expectancy of 12 months or less.

GBD-1100 F06 (10/08) (Rev-1) (TX)

**Proof of Terminal Illness and Examinations:** *Must proof of Terminal Illness be submitted?*

We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

GBD-1100 F07 (10/08)

**Conversion Right:** *If coverage under The Policy ends, do I have a right to convert?*

If Life Insurance coverage or any portion of it under The Policy reduces or terminates for any reason shown in the Termination provision, except nonpayment of premium, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

- 1) the Accidental Death and Dismemberment Benefits; or
- 2) any Amount of Life Insurance for which You or Your Dependents were eligible and not covered;

under The Policy.

If coverage under The Policy terminates because:

- 1) The Policy is terminated; or,
- 2) coverage for an Eligible Class is terminated;

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

- 1) \$10,000; or

- 2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy terminates for any other reason shown in the Termination provision, except nonpayment of premium, the full amount of coverage which ended may be converted.

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

GBD-1100 F09 (10/08) (TX) (Rev-2)

**Conversion:** *How do I convert my coverage or my Dependents' coverage?*

To convert Your coverage or coverage for Your Dependents, You must:

- 1) apply in writing to Us; and
- 2) submit the required premium with the application.

You have the option to convert by voice recording or electronically.

Your application and first premium payment must be received by Us or postmarked within 31 days after Life Insurance terminates. Requests for Conversion may still be accepted by Us if received or postmarked beyond 31 days if:

- 1) You were not given written notice of your right to convert within 15 days of Your Life Insurance terminating; and
- 2) it is received by Us or postmarked no later than 20 days after You were given notice of Your right to convert.

However, even if You were notified late, We will not accept Your application if it is received or postmarked more than 91 days after Life Insurance terminates.

If conversion is applied for or the application is postmarked more than 31 days after Life Insurance terminates, the person who is applying for conversion must be living at that time. We will not accept a conversion application on behalf of a deceased person more than 31 days after Life Insurance terminates.

Any individual policy issued to You or Your Dependents under the Conversion Right:

- 1) will be effective as of the 32<sup>nd</sup> day after the date coverage ends; and
- 2) will be in lieu of coverage for this amount under The Policy.

GBD-1100 F10 (10/08) (TX) (Rev-1)

**Conversion Policy Provisions:** *What are the Conversion Policy provisions?*

The Conversion Policy will:

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

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as The Policy;
- 2) any benefit other than the Life Insurance Benefit; and
- 3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which is being continued:

- 1) in accordance with the Waiver of Premium provision;
- 2) under a certificate of insurance issued in accordance with the Portability provision; or
- 3) in accordance with the Continuation Provisions;

until such coverage ends.

GBD-1100 F11 (10/08) (TX) (Rev-1)

**Death within the Conversion Period:** *What if I or my Dependents die before coverage is converted?*

We will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:

- 1) coverage under The Policy terminates; and
- 2) You or Your Dependent die within 31 days of the date coverage terminates; and
- 3) We receive Proof of Loss.

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

GBD-1100 F12 (10/08)

**Effect of Waiver of Premium on Conversion:** *What happens to the Conversion Policy if Waiver of Premium is later approved?*

If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your or Your Dependent's death under The Policy will be paid only if the individual Conversion Policy is surrendered. The Insurer will refund the premium paid for such Conversion Policy.

GBD-1100 F13 (10/08)

**Portability Benefits:** *What is Portability?*

Portability is a provision which allows You and Your Dependents to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events. Portability applies to Basic and Supplemental Life and the Accidental Death & Dismemberment Benefit.

GBD-1100 F14 (10/08)

**Qualifying Events:** *What are Qualifying Events?*

Qualifying Events for You are:

- 1) Your employment terminates prior to age 85;
- 2) You retire; or
- 3) Your membership in an Eligible Class under The Policy ends due to the exhaustion of Your Leave of Absence, Military Leave of Absence, Lay Off or Family Medical Leave;

provided the Qualifying Event occurs prior to age 85.

Qualifying Events for Your Dependents are:

- 1) Your employment terminates prior to age 85;
- 2) You retire;
- 3) Your death;
- 4) Your membership in a class eligible for Dependents' coverage ends due to the exhaustion of Your Leave of Absence, Military Leave of Absence, Lay Off or Family Medical Leave; or
- 5) he or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;

provided the Qualifying Event occurs prior to age 85.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to Your own Qualifying Event.

GBD-1100 F15 (10/08) (Rev-1)

**Electing Portability:** *How do I elect Portability?*

You may elect Portability for Your coverage after Your Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available.

To elect Portability for You or Your Dependents, You must:

- 1) apply in writing; and
- 2) submit the required premium with the application.

You have the option to elect Portability by voice recording or electronically.

Your application and first premium payment must be received by Us or postmarked within 31 days after Life Insurance terminates. Requests for Portability may still be accepted by Us if received or postmarked beyond 31 days if:

- 1) You were not given notice of your right to port within 15 days of Your Life Insurance terminating; and
- 2) it is received by Us or postmarked no later than 20 days after You were given notice of Your right to port.

However, even if You were notified late, We will not accept your application if it is received or postmarked more than 91 days after Life Insurance terminates.

If Portability is applied for or the application is postmarked more than 31 days after Life Insurance terminates, the person who is applying for portability must be living at that time. We will not accept a portability application on behalf of a deceased person more than 31 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

- 1) issued on one of the forms then being issued by Us for Portability purposes; and
- 2) effective on the 32<sup>nd</sup> day following the date Your or Your Dependent's coverage ends.



The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Evidence of Insurability may be required for amounts elected over the Portability Guaranteed Issue Amount of \$500,000 for You and \$50,000 for Your Spouse. If Evidence of Insurability is not satisfactory to Us, the coverage under the Portability policy will be limited to amounts under the Portability Guaranteed Issue Amount. However, You may be able to convert Your remaining coverage as described in the Conversion Right provision under The Policy.

GBD-1100 F16 (10/08) (Rev-1)

**Limitations:** *What limitations apply to this benefit?*

You may elect to continue up to 50%, 75% or 100% of the Amount of Life Insurance which is ending for You or Your Dependents. This amount will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. However, the Amount of Life Insurance that may be continued will not exceed:

- 1) \$500,000 for You;
- 2) \$50,000 for Your Spouse; or
- 3) \$10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75%, or 100% now, You may not increase the elected amount at a later date.

Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered.

In addition Portability is not available if You or Your Dependents are entering active military service or if You were not Actively at Work due to sickness or Injury on the day prior to termination of coverage.

GBD-1100 F17 (10/08) (Rev-1)

**Effect of Portability on Other Provisions:** *How does Portability affect other Provisions?*

Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

- 1) Conversion Right;
- 2) Waiver of Premium provision; or
- 3) Continuation provisions;

under The Policy. However, if:

- 1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or
- 2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

GBD-1100 F18 (10/08) (Rev-2)

## EXCLUSIONS

**Exclusions:** (Applicable to all benefits except the Life Insurance Benefit and the Accelerated Benefit) *What is not covered under The Policy?*

The Policy does not cover any loss caused or contributed to by:

- 1) anaphylactic shock;
- 2) any form of auto-erotic asphyxiation;
- 3) failure to wear a Seat Belt while driving or riding as a passenger in a Motor Vehicle;
- 4) intentionally self-inflicted Injury;
- 5) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis or aneurysm;
- 6) suicide or attempted suicide, whether sane or insane;
- 7) war or act of war, whether declared or not;
- 8) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority except Reserve or National Guard Service;
- 9) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- 10) Injury sustained while committing or attempting to commit a felony;
- 11) Injury sustained while Intoxicated;
- 12) Injury sustained while driving while Intoxicated;
- 13) Injury sustained by illegal fireworks or the use of any legal fireworks when not following the manufacturer's lighting instructions;
- 14) driving and violating any applicable cellular device use or distracted driving laws; or

- 15) failure to wear a helmet while On or riding as a passenger On a motorcycle, bicycle, all-terrain vehicle (ATV) or any other type of motor bike.

**Intoxicated** means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the laws of the state where the accident occurred. If the accident occurred outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.

**Reserve or National Guard Service** means You or Your Dependents are:

- 1) attending or en route to or from any active duty training of less than sixty (60) days;
- 2) attending or en route to or from a service school of any duration;
- 3) taking part in any authorized inactive duty training; or
- 4) taking part as a unit member in a parade or exhibition authorized by official orders.

PA-9222 G01 (10/08) (Rev-2)

## GENERAL PROVISIONS

**Notice of Claim:** *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us written notice of a claim within 30 days after:

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

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

GBD-1100 H01 (10/08)

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

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

GBD-1100 H02 (10/08)

**Proof of Loss:** *What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

- 1) a completed claim form;
- 2) a certified copy of the death certificate (if applicable);
- 3) Your Enrollment form;
- 4) Your Beneficiary Designation (if applicable);
- 5) documentation of:
  - a) the date Your disability began;
  - b) the cause of Your disability; and
  - c) the prognosis of Your disability;
- 6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 7) the names and addresses of all:
  - a) Physicians or other qualified medical professionals You have consulted;
  - b) hospitals or other medical facilities in which You have been treated; and
  - c) pharmacies which have filled Your prescriptions within the past three years;
- 8) Your signed authorization for Us to obtain and release medical, employment, and financial information (if applicable); or
- 9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

GBD-1100 H03 (10/08)

**Sending Proof of Loss:** *When must Proof of Loss be given?*

Written Proof of Loss should be sent to Us:

- 1) with respect to the Life Insurance Benefits within 365 days; and

2) with respect to the Accidental Death and Dismemberment Benefits within 90 days; after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not reasonably possible to give proof within the required time; and
- 2) proof is given as soon as reasonably possible; but
- 3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

GBD-1100 H04 (10/08) (Rev-1)

**Physical Examination and Autopsy:** *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
- 2) to have an autopsy performed in case of death where it is not forbidden by law.

GBD-1100 H05 (10/08)

**Claim Payment:** *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

GBD-1100 H06 (10/08) (TX)

**Claims to be Paid:** *To whom will benefits for my claim be paid?*

Life Insurance Benefits and benefits for loss of life under the Accidental Death and Dismemberment Benefit will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

- 1) the executors or administrators of Your estate;
- 2) all to Your surviving spouse;
- 3) if Your spouse does not survive You, in equal shares to Your surviving children;
- 4) if no child survives You, in equal shares to Your surviving parents; or
- 5) if no parent survives You, in equal shares to Your surviving siblings.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to \$250 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

- 1) \$200 at Your death; and
- 2) monthly installments of not more than \$200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit and benefits for loss of life under the Accidental Death and Dismemberment Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, We will pay benefits through a draft book account, unless prohibited by law in the state where You or Your beneficiary resides. The draft book account will be owned by:

- 1) You, if living; or
- 2) Your beneficiary, in the event of Your death.

However, an account will not be established for:

- 1) a benefit payable to Your estate; or
- 2) an amount that is less than \$10,000.

In these circumstances, We will pay benefits in a lump sum payment.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

- 1) Your estate;

- 2) a person who is a minor; or
- 3) a person who is not legally competent,

then We may pay up to \$1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Periodic benefit payments will be made on a monthly basis after We receive the Proof of Loss and will continue while the loss and Our liability continue.

GBD-1100 H07 (10/08) (TX) (Rev-2)

**Beneficiary Designation:** *How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

GBD-1100 H08 (10/08)

**Claim Denial:** *What notification will my beneficiary or I receive if a claim is denied?*

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

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

GBD-1100 H10 (10/08)

**Claim Appeal:** *What recourse do my beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

- 1) must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
  - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to the claim; and
- 3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

GBD-1100 H11 (10/08)

**Eligibility Determination:** *How will We determine Your or Your Dependent's eligibility for benefits?*

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

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

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

GBD-1100 H31 (10/08) (TX)

**Incontestability:** *When can the Life Insurance Benefit of The Policy be contested?*

Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

No statement made by You or Your Spouse relating to Your or Your Spouse's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

In the absence of fraud, all statements made by the Policyholder, the Employer or You or Your Spouse under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

If coverage is reinstated per the Reinstatement Provision, the balance of the incontestable period will apply.

GBD-1100 H13 (10/08) (TX)

**Assignment:** *Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

- 1) the right to make any contributions required to keep the insurance in force;
- 2) the right to convert; and
- 3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

GBD-1100 H14 (10/08)

**Legal Actions:** *When can legal action be taken against us?*

Legal action cannot be taken against Us:

- 1) sooner than 180 days after the date written Proof of Loss is furnished; or
- 2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

GBD-1100 H15 (10/08)

**Workers' Compensation:** *How does The Policy affect Workers' Compensation coverage?*

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GBD-1100 H16 (10/08)

**Insurance Fraud:** *How does the Company deal with fraud?*

Insurance fraud occurs when You, Your Dependents and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your Dependents and/or the Employer perpetrate insurance fraud.

GBD-1100 H17 (10/08)

**Misstatements:** *What happens if facts are misstated?*

If material facts about You or Your Dependents were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

GBD-1100 H18 (10/08)

## DEFINITIONS

**Active Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

PA-9221 C01 (10/08)

**Actively at Work** means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

PA-9221 C02 (10/08)

**Common Carrier** means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

PA-9221 C09 (10/08)

**Contributory Coverage** means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

PA-9221 C10 (10/08)

**Dependent Child(ren)** means:

Your natural child, stepchild, adopted child or any other child who is related to You by blood or marriage who is:

- 1) not yet age 26; or
- 2) physically or mentally disabled and living under Your supervision.

Your natural, or adopted grandchildren will qualify as a Dependent provided the child is not yet age 26, or if they are physically or mentally disabled and living under Your supervision.

PA-9221 C13 (10/08) (TX) (Rev-2)

**Dependents** means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, Puerto Rico, Guam and any other locations where We may legally provide such coverage.

PA-9221 C14 (10/08)

**Earnings** means Your regular annual rate of pay, not counting bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date You were last Actively at Work.

However, if You are an hourly paid Active Employee, Earnings means the product of:

- 1) the average number of hours You worked per year, not including overtime, over the most recent 1 year period immediately prior to the date You were last Actively at Work, multiplied by:
- 2) Your hourly wage in effect on the date You were last Actively at Work.

PA-9221 C15 (10/08)

**Employer** means the Policyholder.

PA-9221 C18 (10/08)

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

PA-9221 C20 (10/08)

**Injury** means bodily injury resulting:

- 1) directly from an accident; and

2) independently of all other causes;  
which occurs while You or Your Dependents are covered under The Policy.

Loss resulting from:

- 1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- 2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

PA-9221 C22 (10/08)

**Motor Vehicle** means a self-propelled, four (4) or more wheeled:

- 1) private passenger: car, station wagon, van or sport utility vehicle;
- 2) motor home or camper; or
- 3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

PA-9221 C25 (10/08)

**Non-Contributory Coverage** means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

PA-9221 C26 (10/08)

**Physician** means a person who is:

- 1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Related to You by blood or marriage.

PA-9221 C31 (10/08)

**Prior Policy** means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

PA-9221 C33 (10/08)

**Related** means Your Spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

PA-9221 C34 (10/08)

**Spouse** means Your spouse who:

- 1) is not divorced from You; and
- 2) is not in active full-time military service.

PA-9221 C37 (10/08)

**The Policy** means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

PA-9221 C38 (10/08)

**We, Us or Our** means the insurance company named on the face page of The Policy.

PA-9221 C41 (10/08)

**You or Your** means the person to whom this Certificate of Insurance is issued.

PA-9221 C42 (10/08)



## HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see [www.thehartford.com](http://www.thehartford.com).

### NONINSURANCE SERVICES

**Noninsurance Services** are added support services offered by The Hartford and/or third party vendors that complement insurance provided by The Hartford. These services may assist in making the most of the financial protection the insurance provides.

**Eligibility:** These services may be available at no additional cost and are in addition to the insurance coverage. Participation in these services is voluntary and does not require separate enrollment. Some services may require a loss to participate. Please contact the Policyholder for more information on the available Noninsurance Services with The Hartford.

The following services may be available:

**Will Preparation:** These services provide access to an online tool which includes an educational portal, to assist in creating legally binding and customized wills, living wills and/or trusts. Assistance from licensed attorneys may also be provided.

**Estate Planning:** These services provide support prior to, or following a loss. Services include access to funeral planning tools, and support resources to provide emotional, legal or financial guidance. Additional services may include estate guidance proceedings and durable power of attorney, if needed.

**Financial Planning:** These services provide referrals to financial estate advisors. If a medical emergency happens while traveling, these services may provide help to reduce travel expenses.

**Identity Theft:** These services can assist the beneficiary and family with identity theft prevention. There is also guidance on steps to take if identity theft is suspected or discovered, which include caseworkers who can contact credit reporting agencies.

**Probate and Estate Settlement:** These services provide support and guidance on the administrative tasks associated with probate and estate settlement. Referrals to professional service providers are available.

**Funeral Planning and Bereavement:** These services provide guidance with important decisions before and after a loss. A care team is available to:

- help with funeral plan wishes;
- assist with funeral planning; and
- provide local funeral home price comparisons.

Form PA-10385 (Life) GOV (TX)

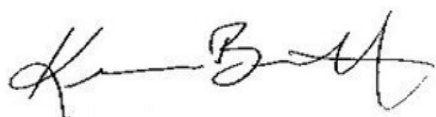


After a loss, these services offer grief support, as well as family advocacy and professional negotiation of funeral prices and other after loss services with local providers. This may expedite claims payments. A secure digital vault is also available to store and share important documents.

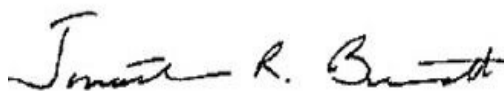
**Termination of Noninsurance Services:** Services end when the underlying Policy terminates, or when the insured is no longer covered under The Policy. If death occurs prior to The Policy termination date, some services will be made available after the termination of coverage.

**Noninsurance Services Vendors:** The third party vendor is liable to the Eligible Person for these services as arranged for by The Hartford. The Hartford is not responsible for the content, performance, accuracy or quality of the vendor services. The Hartford may change vendors or may terminate any Noninsurance Service. Eligible Persons will be given 60 days' notice of termination, unless it is due to circumstances beyond The Hartford's control, such as the vendor terminating its services. You can obtain vendor contact information by visiting [www.thehartford.com](http://www.thehartford.com).

Signed for Hartford Life and Accident Insurance Company



Kevin Barnett, *Secretary*



Jonathan Bennett, *President*

## How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

### For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:**
  - Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is not protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, Texas 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 12030  
Austin, Texas 78711-2030  
1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

**ERISA INFORMATION  
THE FOLLOWING NOTICE  
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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**1. Plan Name**

For employees of :

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**2. Plan Number**

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**3. Employer/Plan Sponsor**

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**4. Employer Identification Number**

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**5. Type of Plan**

Welfare Benefit Plan providing:

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**6. Plan Administrator**

,

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**7. Agent for Service of Legal Process**

For the Plan

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For the Policy:

Hartford Life and Accident Insurance Company  
One Hartford Plaza  
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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**8. Sources of Contributions**

**(Group Life and Accidental Death and Dismemberment)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
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10. The Plan and its records are kept on a Year basis.
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**11. Labor Organizations**

None

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**12. Names and Addresses of Trustees**

None

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**13. Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

### 1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### 2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### 4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

### Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

### **Claim Procedures for Claims Not Requiring a Determination of Disability**

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

#### **Claims for Benefits**

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

#### **Appealing Denials of Claims for Benefits**

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.





# Hartford Life, Inc. - Group Benefits Division

## Customer Statement

### CITY OF VICTORIA

Policy Number: 891798G	Experience Unit: 002	Experience Group: CITY OF VICTORIA-LIFE/ADD
Policy Effective Date: 01/01/2021	Current Policy Status: ACTIVE	Billing System: GIPR
Sales office: HOUSTON	Sales Representative: TROY DAVIS	Service Representative: JENNIFER FINNEGAN
Case Effective Date: 01/01/2021	Current Case Status: ACTIVE	Grace Period: 45 Days

### January 01,2026 through May 01,2026 Account Summary

	Rating Method	Payments Applied to Period	Estimated Due & Unpaid Payments	Estimated Earned premium	Claims Paid in period
Acc Death & Dismemberment Basic	PAR EXCEPTION	\$1,038.23	\$503.11	\$1,541.34	\$45,000.00
LIFE Basic	PAR EXCEPTION	\$4,141.51	\$2,008.13	\$6,149.64	\$45,000.00
LIFE Interest		\$0.00	\$0.00	\$0.00	\$6.85
Total:		\$5,179.74	\$2,511.24	\$7,690.98	\$90,006.85
Grand Total:		\$5,179.74	\$2,511.24	\$7,690.98	\$90,006.85



## Hartford Life, Inc. - Group Benefits Division

### Customer Statement

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#### CITY OF VICTORIA

Policy Number: 891798G	Experience Unit: 003	Experience Group: CITY OF VICTORIA - STD
Policy Effective Date: 01/01/2021	Current Policy Status: ACTIVE	Billing System:GIPR
Sales office: HOUSTON	Sales Representative: TROY DAVIS	Service Representative: JENNIFER FINNEGAN
Case Effective Date: 01/01/2021	Current Case Status: ACTIVE	Grace Period: 45 Days

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#### January 01,2026 through May 01,2026 Account Summary

	Rating Method	Payments Applied to Period	Estimated Due & Unpaid Payments	Estimated Earned premium	Claims Paid in period
Short Term Disability	PAR EXCEPTION	\$9,369.61	\$0.00	\$9,369.61	\$2,661.53
Total:		\$9,369.61	\$0.00	\$9,369.61	\$2,661.53
Grand Total:		\$9,369.61	\$0.00	\$9,369.61	\$2,661.53

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## Hartford Life, Inc. - Group Benefits Division

### Customer Statement

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#### CITY OF VICTORIA

Policy Number: 891798G

Experience Unit: 004

Experience Group: CITY OF VICTORIA - LTD

Policy Effective Date: 01/01/2021

Current Policy Status: ACTIVE

Billing System:GIPR

Sales office: HOUSTON

Sales Representative: TROY DAVIS

Service Representative: JENNIFER FINNEGAN

Case Effective Date: 01/01/2021

Current Case Status: ACTIVE

Grace Period: 45 Days

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#### January 01,2026 through May 01,2026 Account Summary

	Rating Method	Payments Applied to Period	Estimated Due & Unpaid Payments	Estimated Earned premium	Claims Paid in period
Long Term Disability - Ability Assurance	PAR EXCEPTION	\$12,114.83	\$0.00	\$12,114.83	\$10,685.03
Total:		\$12,114.83	\$0.00	\$12,114.83	\$10,685.03
Grand Total:		\$12,114.83	\$0.00	\$12,114.83	\$10,685.03

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# Hartford Life, Inc. - Group Benefits Division

## Customer Statement

### CITY OF VICTORIA

Policy Number: 891798G	Experience Unit: 005	Experience Group: CITY VICTORIA-SP LIFE/SUP ADD
Policy Effective Date: 01/01/2021	Current Policy Status: ACTIVE	Billing System: GIPR
Sales office: HOUSTON	Sales Representative: TROY DAVIS	Service Representative: JENNIFER FINNEGAN
Case Effective Date: 01/01/2021	Current Case Status: ACTIVE	Grace Period: 45 Days

### January 01,2026 through May 01,2026 Account Summary

	Rating Method	Payments Applied to Period	Estimated Due & Unpaid Payments	Estimated Earned premium	Claims Paid in period
Acc Death & Dismemberment Interest		\$0.00	\$0.00	\$0.00	\$6.85
Acc Death & Dismemberment Supplemental	PAR EXCEPTION	\$2,055.36	\$0.00	\$2,055.36	\$106,500.00
LIFE Supplemental Dependent	PAR EXCEPTION	\$2,129.39	\$0.00	\$2,129.39	\$0.00
LIFE Voluntary	PAR EXCEPTION	\$20,464.80	\$0.00	\$20,464.80	\$89,000.00
Total:		\$24,649.55	\$0.00	\$24,649.55	\$195,506.85
Grand Total:		\$24,649.55	\$0.00	\$24,649.55	\$195,506.85



# Hartford Life, Inc. - Group Benefits Division

## Customer Statement

### CITY OF VICTORIA

Policy Number:ALL

Experience Group: ALL

Sales office: HOUSTON

Case Effective Date: 01/01/2021

Current Policy Status: ACTIVE

Sales Representative: TROY DAVIS

Current Case Status: ACTIVE

Billing System:GIPR

Service Representative: JENNIFER FINNEGAN

Grace Period: 45 Days

### January 01,2026 through May 01,2026 Account Summary

	Rating Method	Payments Applied to Period	Estimated Due & Unpaid Payments	Estimated Earned premium	Claims Paid in period
Acc Death & Dismemberment Basic	PAR EXCEPTION	\$1,038.23	\$503.11	\$1,541.34	\$45,000.00
Acc Death & Dismemberment Interest		\$0.00	\$0.00	\$0.00	\$6.85
Acc Death & Dismemberment Supplemental	PAR EXCEPTION	\$2,055.36	\$0.00	\$2,055.36	\$106,500.00
LIFE Basic	PAR EXCEPTION	\$4,141.51	\$2,008.13	\$6,149.64	\$45,000.00
LIFE Interest		\$0.00	\$0.00	\$0.00	\$6.85
LIFE Supplemental Dependent	PAR EXCEPTION	\$2,129.39	\$0.00	\$2,129.39	\$0.00
LIFE Voluntary	PAR EXCEPTION	\$20,464.80	\$0.00	\$20,464.80	\$89,000.00
Total:		\$29,829.29	\$2,511.24	\$32,340.53	\$285,513.70
Long Term Disability - Ability Assurance	PAR EXCEPTION	\$12,114.83	\$0.00	\$12,114.83	\$10,685.03
Total:		\$12,114.83	\$0.00	\$12,114.83	\$10,685.03
Short Term Disability	PAR EXCEPTION	\$9,369.61	\$0.00	\$9,369.61	\$2,661.53
Total:		\$9,369.61	\$0.00	\$9,369.61	\$2,661.53
Grand Total:		\$51,313.73	\$2,511.24	\$53,824.97	\$298,860.26

End Of Report



## Hartford Life, Inc. - Group Benefits Division

### Customer Statement

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End of the Report

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## **ATTACHMENT B: STANDARD TERMS AND CONDITIONS**

**AGREEMENT:** This set of Terms and Conditions is incorporated into a Contract in its entirety and, upon execution of the Contract by both Parties, constitutes a portion of the Parties' Agreement. No change, modification or revision to the Agreement shall be binding unless made in writing and signed by the Parties. The City will not in any manner be responsible for goods delivered or work done for our account without a written order.

**DEFINED TERMS:** Where utilized in this Request for Proposals, Contract, requirements/specifications, or elsewhere, the following defined terms shall have the meaning assigned to them:

1. "Contract Documents" means the its terms and conditions, the technical specifications, requirements, specifications, addendum, and amendments, all of which comprise the full agreement of the Parties.

**ACCEPTANCE:** Acceptance of this Standard Terms and Conditions shall be deemed effective upon the City's execution of this Contract or upon shipment of the goods which are the subject of this Contract, whichever occurs first. Any proposal made by Respondent for additional or different terms and conditions or any attempts by Respondent to vary, in any degree, any of the terms and conditions of this Contract is hereby rejected.

**COMPLETION: TIME IS OF THE ESSENCE IN THE PERFORMANCE OF THIS CONTRACT.** If Respondent fails to effect delivery or performance of the associated services required by the City in accordance with the project schedule, delivery schedule, or other time requirements as communicated to Respondent in the Contract or its attachments, in addition to its other rights and remedies hereunder, the City shall have the right to terminate this Contract by notice effective when received by Respondent or after the expiration of five days from the date of mailing of such notice, whichever occurs first. Such termination shall be effective as to goods not yet received by the City or services not yet rendered, regardless of their transit status. Thereafter, the City shall have the right to purchase substitute goods or services elsewhere and charge Respondent with any and all losses, costs and expenses, including, but not limited to actual, consequential and incidental damages, reasonable attorneys' fees, and engineering or consulting fees incurred by the City by reason of such delay or termination.

**PRICES:** Respondent warrants that the prices shown hereunder are the prices quoted to the City at the time of sale and include all costs incurred by Respondent for shipment of all goods included in this Contract. In the event of any price reduction between execution of the Contract and delivery of the goods, the City shall be entitled to such reduction.

**RESPONSIBILITY FOR COMPLETION:** Respondent represents that it has examined the requirements/specifications, schedule, and other documentation in the Contract Documents which Respondent acknowledges are full and complete and are sufficient to enable Respondent to determine the cost of the materials and has fully acquainted itself with all conditions relevant to the work and materials on the Project site and assumes the risk of any variance between the actual conditions and those set out in Contract Documents. Any failure by the City at any time, or from time to time, to enforce

or require the strict keeping and performance of any of the terms or conditions of this Contract shall not constitute a waiver of such terms or conditions and shall not affect or impair such terms or conditions in any way, or the right of the City at any time to avail itself of such remedies, as it may have for any breach or breaches of such terms or conditions.

**WARRANTIES / GUARANTEES:** Respondent expressly warrants that the items and services covered hereunder shall be free of defects in workmanship and shall strictly conform to applicable specifications, instructions, drawings, etc. These warranties shall be in addition to all warranties, express, implied or statutory. All warranties shall run to Buyer, its customers and subsequent owners of items or services covered hereunder.

**INDEMNIFICATION:** TO THE FULLEST EXTENT PERMITTED BY LAW, RESPONDENT SHALL INDEMNIFY, DEFEND AND HOLD HARMLESS THE CITY OF VICTORIA AND ITS OFFICERS, DIRECTORS, AGENTS, REPRESENTATIVES, EMPLOYEES FROM AND AGAINST ALL CLAIMS, LOSSES, EXPENSES, COSTS, DEMANDS, SUITS, CAUSES OF ACTION, AND DAMAGES, INCLUDING WITHOUT LIMITATION, ATTORNEYS' FEES, ENGINEERING OR OTHER CONSULTANTS' FEES, OF ANY KINDS RESULTING FROM RESPONDENT'S PERFORMANCE OR NONPERFORMANCE OF ITS OBLIGATIONS PURSUANT TO THIS PURCHASE ORDER, FAILURE OF GOODS, OR ACTS RESULTING IN BODILY INJURY OR PROPERTY DAMAGE, BUT ONLY TO THE EXTENT OF THE NEGLIGENCE OR OTHER FAULT OF RESPONDENT, ITS AGENTS, REPRESENTATIVES, EMPLOYEES OR SUBCONTRACTORS OF ANY TIER.

**NO DAMAGES FOR DELAY:** Respondent shall have no right to claim any damages against the City, including consequential or incidental damages, as a result of delay. Extension of time for Respondent's performance is conditioned upon the City's approval of an extension of time to the contract or delays claimed by Respondent. Failure of Respondent to make a claim promptly shall be deemed a waiver of the right to a claim for an extension of time for the particular cause.

**TERMINATION:** The City may terminate this Contract or any part thereof for cause in the event of any default by Respondent, or if Respondent fails to comply with any of the terms and conditions of this offer. The Uniform Commercial Code of the State of Texas shall apply to the City's rights and remedies under commercial transactions. The City reserves all rights, remedies, and warranties, express and implied, under the UCC. Respondent may not terminate this Contract unless the City fails to provide payment for goods and/or associated services expressly accepted by the City.

**TAXES:** The City of Victoria is exempted from all city, state, and federal excise taxes. DO NOT include tax on your invoice.

**INSURANCE:** In the event that Respondent's performance hereunder requires or contemplates the performance of services by Respondent's employees, or other persons under contract to Respondent, whether such services are to be performed at the place of delivery of such goods or services, or elsewhere, Respondent agrees that any such



performance of services shall be done as an independent contractor and that the persons doing such work shall not be considered employees of the City.

**PAYMENT:** Invoices will be paid according to agreed payment terms as reflected in the purchase order or within 30 days after receipt of the items or completion of required services. Payment for the goods delivered under this Contract shall not be acceptance of such goods. Goods shall only be deemed accepted when they have actually been counted, inspected, and tested by the City and found to be in conformance with this Contract. However, failure to inspect or test by the City shall not relieve Respondent of any responsibility hereunder.

**REMEDIES:** The rights and remedies reserved to the City herein, except where expressly stated to be exclusive, shall be cumulative and in addition to any other or further rights and remedies provided by law or equity. No waiver of any breach of these provisions shall be deemed to constitute a waiver of any other breach.

**ASSIGNMENT:** Neither this Contract nor any right or obligations herein may be assigned by Respondent nor may Respondent delegate the performance of any of its duties hereunder without in either case the City's prior written consent.

**FORCE MAJEURE:** Either party to this Contract shall be free from liability for failing to perform hereunder if such failure is caused due to acts of God, labor difficulties, fires or other causes beyond the reasonable control of the affected party. In the event that Respondent is unable to perform for such reasons beyond its reasonable control, the City shall have the right to either continue the delivery dates until Respondent is able to perform or terminate this Contract.

**DISPUTE RESOLUTION:** In the event of disputes over price, quantity or quality, the City shall have the right to audit Respondent's records in order to resolve the dispute. Pending resolution of the dispute, amicably or otherwise, Respondent shall proceed diligently with the performance of this Contract as directed by the City. The Contract shall be governed by the laws of the State of Texas. In the event that a dispute arises between the City and Respondent, the parties agree that the exclusive venue to submit said disputes is the State District Courts of Victoria County, Texas for resolution.

**SENATE BILL 13:** Contractor understands and agrees that it does not boycott energy companies and will not boycott energy companies during contract term for contracts with entities with at least 10-full time employee and that is valued at \$100,000 or greater.

**SENATE BILL 19:** Contractor agrees and understands that it does not have a practice, policy, guidance or directive that discriminates against a firearm entity or trade association and will not discriminate during the term of the contract for contracts valued at \$100,000 or greater.

**SENATE BILL 943:** Contractor agrees and understands that for contracts that are worth more than \$1,000,000, contractor shall preserve all contracting information as provided by the records retention requirements applicable to the City for the duration of the contract, promptly provide the City any contracting information that is in the custody or possession of the vendor upon request, and on completion of the contract, either (a) provide, at no cost to the City, all contracting information that is in the vendor's custody or possession, or (b) provide preserve the contracting information as provided by the records retention requirements applicable to the City.

**The City:**  
**The City of Victoria, Texas**

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

**Respondent:**  
\_\_\_\_\_,  
a \_\_\_\_\_

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_

**Exhibit A**  
**Owner's Insurance Requirements**

**1. Specific Insurance Requirements**

The following insurance shall be maintained in effect with limits not less than those set forth below at all times during the term of this Agreement and thereafter as required:

Insurance	Coverage/Limits	Other Requirements
Commercial General Liability (Occurrence Basis)	<p>Amounts of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ \$1,000,000 Per Occurrence</li> <li>▪ \$2,000,000 General Aggregate</li> <li>▪ \$2,000,000 Products/Completed Operations Aggregate</li> <li>▪ \$1,000,000 Personal and Advertising Injury</li> <li>▪ Designated Construction Project(s) General Aggregate Limit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Current ISO edition of CG 00 01</li> <li>▪ Additional insured status shall be provided in favor of Owner Parties on a combination of ISO forms CG 20 10 04 13 and CG 20 37 04 13.</li> <li>▪ This coverage shall be endorsed to provide primary and non-contributing liability coverage. It is the intent of the parties to this Agreement that all insurance coverage required herein shall be primary to and will not seek contribution from any other insurance held by Owner Parties, with Owner Parties' insurance being excess, secondary and non-contributing.</li> <li>▪ Stop Gap coverage shall be provided if any work is to be performed in a monopolistic workers' compensation state.</li> <li>▪ The following exclusions/limitations (or their equivalent(s), are prohibited: <ul style="list-style-type: none"> <li>○ Contractual Liability Limitation CG 21 39</li> <li>○ Amendment of Insured Contract Definition CG 24 26</li> <li>○ Limitation of Coverage to Designated Premises or Project, CG 21 44</li> <li>○ Exclusion-Damage to Work Performed by Subcontractors on Your Behalf, CG 22 94 or CG 22 95</li> <li>○ Exclusion-Explosion, Collapse and Underground Property Damage Hazard, CG 21 42 or CG 21 43</li> <li>○ Any Classification limitation</li> <li>○ Any Construction Defect Completed Operations exclusion</li> <li>○ Any endorsement modifying the Employer's Liability exclusion or deleting the exception to it</li> <li>○ Any endorsement modifying or deleting Explosion, Collapse or Underground coverage</li> <li>○ Any Habitational or Residential exclusion applicable to the Work</li> <li>○ Any "Insured vs. Insured" exclusion except Named Insured vs. Named Insured</li> <li>○ Any Punitive, Exemplary or Multiplied Damages exclusion</li> <li>○ Any Subsidence exclusion</li> </ul> </li> </ul>

Business Auto Liability	<p>Amount of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ \$1,000,000 Per Accident</li> </ul>	<ul style="list-style-type: none"> <li>▪ Current ISO edition of CA 00 01</li> <li>▪ Arising out of any auto (Symbol 1), including owned, hired and non-owned</li> </ul>
Workers' Compensation and Employer's Liability	<p>Amounts of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ Statutory Limits</li> <li>▪ \$1,000,000 Each Accident and Disease</li> <li>▪ Alternate Employer endorsement</li> <li>▪ USL&amp;H must be provided where such exposure exists.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The State in which work is to be performed must listed under Item 3.A. on the Information Page</li> <li>▪ Such insurance shall cover liability arising out of the Contractor's employment of workers and anyone for whom the Contractor may be liable for workers' compensation claims. Workers' compensation insurance is required, and no "alternative" forms of insurance shall be permitted.</li> <li>▪ Where a Professional Employer Organization (PEO) or "leased employees" are utilized, Contractor shall require its leasing company to provide Workers' Compensation insurance for said workers and such policy shall be endorsed to provide an Alternate Employer endorsement in favor of Contractor and Owner. Where Contractor uses leased employees with Workers' Compensation insurance provided by a PEO or employee leasing company, Contractor is strictly prohibited from subletting any of its work without the express written agreement of Owner.</li> </ul>
Excess Liability (Occurrence Basis)	<p>Amounts of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ \$5,000,000 Each Occurrence</li> <li>▪ \$5,000,000 Annual Aggregate</li> </ul>	<ul style="list-style-type: none"> <li>▪ Such insurance shall be excess over and be no less broad than all coverages described above.</li> <li>▪ Drop-down coverage shall be provided for reduction and/or exhaustion of underlying aggregate limits and shall include a duty to defend any insured.</li> </ul>
Professional Liability	<p>Amounts of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ \$1,000,000 Each Occurrence</li> <li>▪ \$2,000,000 Annual Aggregate</li> <li>▪ If a combined Contractor's Pollution Liability and Professional Liability policy is utilized, the limits shall be \$3,000,000 Each Loss and Aggregate.</li> <li>▪ Such insurance shall cover all services rendered by the Contractor and its consultants under the Agreement, including but not limited to design or design/build services.</li> <li>▪ Policies written on a Claims-Made basis shall be maintained for at least two years beyond termination of the Agreement.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Such insurance shall cover all services rendered by the Contractor and its subcontractors under the Agreement.</li> <li>▪ This insurance is not permitted to include any type of exclusion or limitation of coverage applicable to claims arising from: <ul style="list-style-type: none"> <li>○ bodily injury or property damage where coverage is provided in behalf of design professionals or design/build contractors</li> <li>○ habitational or residential operations</li> <li>○ mold and/or microbial matter and/or fungus and/or biological substance</li> <li>○ punitive, exemplary or multiplied damages.</li> </ul> </li> <li>▪ Any retroactive date must be effective prior to beginning of services for the Owner.</li> <li>▪ Policies written on a Claims-Made basis shall have an extended reporting period of at least two years beyond termination of the Agreement. Vendor shall trigger the extended</li> </ul>

		reporting period if identical coverage is not otherwise maintained with the expiring retroactive date.
Contractors Pollution Liability	<p>Amounts of coverage shall be no less than:</p> <ul style="list-style-type: none"> <li>▪ \$1,000,000 Each Loss</li> <li>▪ \$2,000,000 Annual Aggregate</li> <li>▪ If a combined Contractor's Pollution Liability and Professional Liability policy is utilized, the limits shall be \$3,000,000 Each Loss and Aggregate.</li> <li>▪ The policy must provide coverage for: <ul style="list-style-type: none"> <li>○ the full scope of the named insured's operations (on-going and completed) as described within the scope of work for this Agreement</li> <li>○ loss arising from pollutants including but not limited to fungus, bacteria, biological substances, mold, microbial matter, asbestos, lead, silica and contaminated drywall</li> <li>○ third party liability for bodily injury, property damage, clean up expenses, and defense arising from the operations;</li> <li>○ diminution of value and Natural Resources damages</li> <li>○ contractual liability</li> <li>○ claims arising from non-owned disposal sites utilized in the performance of this Agreement.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ The policy must insure contractual liability, name Owner Parties as an Additional Insured, and be primary and noncontributory to all coverage available to the Additional Insured.</li> <li>▪ This insurance is not permitted to include any type of exclusion or limitation of coverage applicable to claims arising from: <ul style="list-style-type: none"> <li>○ Insured vs. insured actions. However, exclusion for claims made between insured within the same economic family are acceptable.</li> <li>○ impaired property that has not been physically injured</li> <li>○ materials supplied or handled by the named insured. However, exclusions for the sale and manufacture of products are allowed. Exclusionary language pertaining to materials supplied by the insured shall be reviewed by the certificate holder for approval.</li> <li>○ property damage to the work performed by the contractor</li> <li>○ faulty workmanship as it relates to clean up costs</li> <li>○ punitive, exemplary or multiplied damages</li> <li>○ work performed by subcontractors</li> </ul> </li> <li>▪ If coverage is provided on a Claims Made basis, coverage will at least be retroactive to the earlier of the date of this Agreement or the commencement of contractor services relation to the Work.</li> <li>▪ The policy will offer an extended discovery or extended reporting clause of at least three (3) years.</li> <li>▪ Completed Operations coverage shall be maintained through the purchase of renewal policies to protect the insured and additional insured for at least two (2) years after the property owner accepts the project or this contract is terminated. The purchase of an extended discovery period or an extended reporting period on a Claims Made policy or the purchase of occurrence-based Contractors Environmental Insurance will not be sufficient to meet the terms of this provision.</li> </ul>

## **2. General Insurance Requirements**

### **A. Definitions. For purposes of this Agreement:**

- i. "ISO" means Insurance Services Office.
- ii. "Contractor" shall include the Builder and its subcontractors of any tier.
- iii. "Owner Parties" means (a) City of Victoria, Texas (collectively referred to as "Owner"), (b) the Project, (c) any lender whose loan is secured by a lien against the Work, (d) their respective shareholders, members, partners, joint venture's, affiliates, subsidiaries, successors and assigns, (e) any directors, officers, employees, or agents of such persons or entities, and (f) others as required by the Contract Documents.

### **B. Policies.**

- i. Contractor shall maintain such Excess Liability, Professional and Pollution insurance in identical coverage, form and amount, including required endorsements, for at least two (2) years following Date of Substantial Completion of the Work to be performed under this Agreement. Contractor shall maintain such General Liability insurance in identical coverage, form and amount, including required endorsements, for at least ten (10) years following Date of Substantial Completion of the Work to be performed under this Agreement. Contractor shall provide written representation to Owner stating Work completion date.
- ii. All policies must:
  - a. Be written through insurance companies authorized to do business in the State in which the work is to be performed and rated no less than A-: VII in the most current edition of A. M. Best's Key Rating Guide at all times Work is to be performed.
  - b. Provide a waiver of subrogation in favor of Owner Parties on all insurance coverage carried by Contractor, whether required herein or not.
  - c. Contain an endorsement providing for thirty (30) days prior written notice of cancellation to Owner.
  - d. Be provided to the Owner Parties in compliance with the requirements herein and shall contain no endorsements that restrict, limit, or exclude coverage required herein in any manner without the prior express written approval of the Owner.
- iii. Failure of any Owner Party to demand such certificate or other evidence of full compliance with these insurance requirements or failure of any Owner Party to identify a deficiency from evidence that is provided shall not be construed as a waiver of the Contractor's obligation to maintain such insurance.
- iv. Contractor shall provide to the Owner a certified copy of all insurance policies required herein within ten (10) days of any such request. Renewal policies, if necessary, shall be delivered to the Owner prior to the expiration of the previous policy.
- v. Commencement of Work without provision of the required certificate of insurance, evidence of insurance or required endorsements, or without compliance with any other provision of this Agreement, shall not constitute a waiver by any Owner Party of any rights. The Owner shall have the right, but not the obligation, of prohibiting the Contractor or any subcontractor from performing any Work until such certificate of insurance, evidence of insurance and/or required endorsements are received and approved by the Owner.

### **C. Limits, Deductibles and Retentions**

- i. The limits of liability may be provided by a single policy of insurance or by a combination of primary and excess policies, but in no event shall the total limits of liability available for any one occurrence or accident be less than the amount required herein.
- ii. No deductible or self-insured retention shall exceed \$25,000 without prior written approval of the Owner, except as otherwise specified herein. All deductibles or retentions shall be paid by, assumed by, for the account of, and at the Contractor's sole risk. The Contractor shall not be reimbursed for same.

**D. Forms**

- i. If the forms of policies, endorsements, certificates or evidence of insurance required by this Exhibit A are superseded or discontinued, Owner will have the right to require other equivalent forms.
- ii. Any policy or endorsement form other than a form specified in this Exhibit A must be approved in advance by Owner.

**E. Evidence of Insurance.** Insurance must be evidenced as follows:

- i. ACORD Form 25 Certificate of Liability Insurance for liability coverages.
- ii. ACORD Form 28 Evidence of Commercial Property Insurance for property coverages.
- iii. Evidence shall be provided to Owner prior to commencing Work and prior to the expiration of any required coverage.
- iv. ACORD Forms specify:
  - a. Owner as certificate holder at Owner's mailing address;
  - b. Insured's name, which must match that on this Agreement;
  - c. Insurance companies producing each coverage and the policy number and policy date of each coverage;
  - d. Producer of the certificate with correct address and phone number and have the signature of the authorized representative of the producer;
  - e. Additional Insured status in favor of Owner Parties;
  - f. Amount of any deductible or self-insured retention in excess of \$25,000;
  - g. Designated Construction Project(s) General Aggregate Limit;
  - h. Primary and non-contributory status;
  - i. Waivers of subrogation; and
  - j. All exclusions and limitations added by endorsement to the General Liability coverage. This can be achieved by attachment of the Schedule of Forms and Endorsements page.
- v. Copies of the following shall also be provided:
  - a. General Liability Additional insured endorsement(s);
  - b. General Liability Schedule of Forms and Endorsements page(s); and
  - c. 30 Day Notice of Cancellation endorsement applicable to all required policies.

**F. Contractor Insurance Representations to Owner Parties**

- i. It is expressly understood and agreed that the insurance coverages required herein (a) represent Owner Parties' minimum requirements and are not to be construed to void or limit the Contractor's indemnity obligations as contained in this Agreement nor represent in any manner a determination of the insurance coverages the Contractor should or should not maintain for its own protection; and (b) are being, or have been, obtained by the Contractor in support of the Contractor's liability and indemnity obligations under this Agreement. Irrespective of the requirements as to insurance to be carried as provided for herein, the insolvency, bankruptcy or failure of any insurance company carrying insurance of the Contractor, or the failure of any insurance company to pay claims accruing, shall not be held to affect, negate or waive any of the provisions of this Agreement.
- ii. Failure to obtain and maintain the required insurance shall constitute a material breach of, and default under, this Agreement. If the Contractor shall fail to remedy such breach within five (5) business days after notice by the Owner, the Contractor will be liable for any and all costs, liabilities, damages and penalties resulting to the Owner Parties from such breach, unless a written waiver of the specific insurance requirement(s) is provided to the Contractor by the Owner. In the event of any failure by the Contractor to comply with the provisions of this Agreement, the Owner may, without in any way compromising or waiving any right or remedy at law or in equity, on notice to the Contractor, purchase such insurance, at the Contractor's expense, provided that the Owner shall have no obligation to do so and if the Owner shall do so, the Contractor shall not be relieved of or excused from the obligation to obtain and maintain such insurance amounts and coverages.
- iii. This Exhibit A is an independent contract provision and shall survive the termination or expiration of the Contract Agreement.

**G. Insurance Requirements of Contractor's Subcontractors**

- i. Insurance similar to that required of the Contractor shall be provided by all subcontractors (or provided by the Contractor on behalf of subcontractors) to cover operations performed under any subcontract agreement. The Contractor shall be held responsible for any modification in these insurance requirements as they apply to subcontractors. The Contractor shall maintain certificates of insurance from all subcontractors containing provisions similar to those listed herein (modified to recognize that the certificate is from subcontractor) enumerating, among other things, the waivers of subrogation, additional insured status, and primary liability as required herein, and make them available to the Owner upon request.

The Contractor is fully responsible for loss and damage to its property on the site, including tools and equipment, and shall take necessary precautions to prevent damage to or vandalism, theft, burglary, pilferage and unexplained disappearance of property. Any insurance covering the Contractor's or its subcontractor's property shall be the Contractor's and its subcontractor's sole and complete means or recovery for any such loss. To the extent any loss is not covered by said insurance or subject to any deductible or co-insurance, the Contractor shall not be reimbursed for same. Should the Contractor or its subcontractors choose to self-insure this risk, it is expressly agreed that the Contractor hereby waives, and shall cause its subcontractors to waive, any claim for damage or loss to said property in favor of the Owner Parties.

**H. Use of the Owners Equipment**

The Contractor, its agents, employees, subcontractors or suppliers shall use the Owners equipment only with express written permission of the Owners designated representative and in accordance with the Owners terms and condition for such use. IF THE CONTRACTOR OR ANY OF ITS AGENTS, EMPLOYEES, SUBCONTRACTORS OR SUPPLIERS UTILIZE ANY OF THE OWNERS EQUIPMENT FOR ANY PURPOSE, INCLUDING MACHINERY, TOOLS, SCAFFOLDING, HOISTS, LIFTS OR SIMILAR ITEMS OWNED, LEASED OR UNDER THE CONTROL OF THE OWNER, THE CONTRACTOR SHALL DEFEND, INDEMNIFY AND BE LIABLE TO THE OWNER PARTIES FOR ANY AND ALL LOSS OR DAMAGE WHICH MAY ARISE FROM SUCH USE.

**I. Release and Waiver**

The Contractor hereby releases, and shall cause its subcontractors to release, the Owner Parties from any and all claims or causes of action whatsoever which the Contractor or its subcontractors might otherwise now or hereafter possess resulting in or from or in any way connected with any loss covered by insurance, whether required herein or not, or which should have been covered by insurance required herein, including the deductible or uninsured portion thereof, maintained or required to be maintained by the Contractor or its subcontractors pursuant to this Agreement. **THE FOREGOING RELEASE AND WAIVER APPLY EVEN IF THE LOSS OR DAMAGE IS CAUSED IN WHOLE OR IN PART BY THE FAULT OR NEGLIGENCE OR STRICT LIABILITY OF THE OWNER PARTIES.**



## ATTACHMENT C: ISRAEL VERIFICATION FORM

I, \_\_\_\_\_, the undersigned representative of \_\_\_\_\_ (the "Company") being an adult over the age of eighteen (18) years of age, after being duly sworn by the undersigned notary, do hereby declare, represent, and verify under oath that the Company, under the provisions of Chapter 2270 of the Texas Government Code, as amended:

1. does not boycott Israel currently; and
2. will not boycott Israel during the term of the contract.

Pursuant to Section 2270.001 of the Texas Government Code:

1. "Boycott Israel" means refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations specifically with Israel, or with a person or entity doing business in Israel or in an Israeli-controlled territory, but does not include an action made for ordinary business purposes; and
2. "Company" means a for-profit sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, or limited liability company, including a wholly owned subsidiary, majority-owned subsidiary, parent company, or affiliate of those entities or business associations that exist to make a profit.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF COMPANY REPRESENTATIVE

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally appeared \_\_\_\_\_, the above-named person, who after by me being duly sworn, did swear and confirm that the above is true and correct.

NOTARY SEAL

\_\_\_\_\_  
NOTARY SIGNATURE

\_\_\_\_\_  
Date

**ATTACHMENT D - FORM OF NON-COLLUSIVE AFFIDAVIT**

STATE OF TEXAS, COUNTY OF VICTORIA

\_\_\_\_\_, being first duly sworn, deposes and says that he is

\_\_\_\_\_  
(a partner or officer of the firm of, etc.)

the party making the foregoing proposal, that such proposal is genuine and not collusive or sham; that said proposer has not colluded, conspired, connived or agreed, directly or indirectly, with any manner, directly or indirectly, sought by agreement or collusion, or communication or conference with any person to fix the proposal price or affiant or of any other proposer, or to fix any overhead, profit, or cost element of said proposal price, or of that of any other proposer, or to secure any advantage against

**THE CITY OF VICTORIA**

or of any person interested in the proposed Contract; and that all statements in said proposal are true.

\_\_\_\_\_  
Signature of Proposer, if Proposer is an  
Individual

\_\_\_\_\_  
Signature of Proposer, if Proposer is a  
Partnership

\_\_\_\_\_  
Signature of Officer, if Proposer is a  
Corporation

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_

## ATTACHMENT E – RESPONSE QUESTIONNAIRE & CHECKLIST

Item	Note	Respondent's Initials
1. General Requirements for Responses (pgs.1-10)	I acknowledge reading and understanding the General Requirements for Proposals	
2. Scope of Work (pgs.16-33)	I acknowledge reading and understanding the Scope of work	
3. Standard Terms & Conditions (pgs.176-179)	I acknowledge reading and understanding the Standard Terms & Conditions.	
4. Exhibit A – Insurance Rider (pgs.180-185)	I acknowledge reading and understanding the Insurance Rider.	
5. Excel Documents - Benefits Plan	I acknowledge reading and understanding the Benefits Plan.	

### **DID YOU REMEMBER TO:**

6. Fill out, sign and return Response Form A (pg.11)	
7. Fill out, sign and return Response Form B (pgs.12-15)	
8. Fill out, sign and return Israel Verification Form (pg.186)	
9. Fill out and return the Non-Collusion Affidavit and have it Notarized (pg.187)	
10. Review and include information needed for selection criteria	
11. . Fill out and return Response Questionnaire & Checklist (pg.188)	