

Group Long Term Disability Insurance

Employee Benefit Booklet



CITY OF MANDAN

F015948-0001

Class 1-01

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

02/11/2015

Dearborn National[®] Life Insurance Company

Group Certificate

Dearborn National Life Insurance Company

Chicago, Illinois

Administrative Office: 1020 31st Street • Downers Grove, IL 60515

Having issued Group Policy No. **F015948-0001**

(herein called the Policy or this Plan)

to

CITY OF MANDAN

(herein called the Policyholder)

CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy. It takes effect on the effective date stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This certificate describes *Your* eligibility for benefits and the terms and provisions of the Policy. It replaces and cancels any other certificate previously issued to *You* under the Policy.

If for any reason you decide not to keep this Certificate, it may be returned to the Company within 10 days of delivery. Any premiums that may have been paid will be returned. Coverage will be null and void as of the effective date.

00200-ND

If the terms and provisions of the Certificate of Coverage (issued to *You*) are different from the policy (issued to the *Policyholder*), the Policy will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn National Life Insurance Company



Secretary



President

Group Long Term Disability Certificate

Non-Participating

THIS IS NOT A WORKERS' COMPENSATION CERTIFICATE

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DEFINITIONS

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SCHEDULE OF BENEFITS

<i>Policyholder:</i>	CITY OF MANDAN
Policy Number:	F015948-0001
Effective Date:	January 1, 2015
Eligibility:	<p>The following are eligible: All active full-time employees.</p> <p>A full-time employee is one who regularly works a minimum of 30 hours per week for the <i>Policyholder</i>. Part-time, seasonal and temporary employees of the <i>Policyholder</i> are not eligible.</p>
Waiting Period:	<p>If <i>You</i> are in a class eligible for insurance on or before the Policy Effective Date: None</p> <p>If <i>You</i> enter a class eligible for insurance after the Policy Effective Date: First of the month following 0 Days of continuous, full-time active work</p>
Elimination Period:	180 Days
LTD Monthly Benefit:	66 2/3% of <i>Monthly Earnings</i> to a <i>Maximum Gross Monthly Benefit</i> of \$6,000.00 per month subject to reduction by deductible sources of income or <i>Disability Earnings</i>
Social Security Offset Method:	Primary & Family
Minimum Monthly Benefit:	\$100.00 or 10% of <i>Your Gross LTD Monthly Benefit</i> , whichever is greater
Policyholder Contribution:	100% of premium

Maximum Period Payable:	Age on Date <i>Disability Commences</i>	Maximum Period Payable
	Less than 60	To SSNRA*
	60	60 months or to SSNRA*, whichever is greater
	61	48 months or to SSNRA*, whichever is greater
	62	42 months or to SSNRA*, whichever is greater
	63	36 months or to SSNRA*, whichever is greater
	64	30 months or to SSNRA*, whichever is greater
	65	24 months
	66	21 months
	67	18 months
	68	15 months
	69 or over	12 months

* Social Security Normal Retirement Ages Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth.

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943-1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

OTHER FEATURES

The following other features are included:

- Waiver of Premium
- Work Incentive Benefit
- Rehabilitation Incentive Income
- Recurrent Disability
- FMLA Coverage Extension
- Survivor Benefit
- Rehabilitation Benefit
- Day Care Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.

ELIGIBILITY AND EFFECTIVE DATES

Who is eligible for this insurance?

The following people are eligible: All active full-time employees.

The *Waiting Period* is shown in the *Schedule of Benefits*.

00001

When does Your Noncontributory insurance become effective?

If *You* are an eligible Employee, *Your Noncontributory* coverage under the Policy will become effective on the day following completion of the *Waiting Period*, if any, shown in the Schedule of Benefits, provided you are *Actively at Work* on that day.

If *You* waive all or a portion of *Your Noncontributory* coverage and choose to enroll at a later date, *You* are considered a late applicant and must furnish *Evidence of Insurability satisfactory to Us* before coverage can become effective. Coverage will become effective on the date *We* determine that the *Evidence of Insurability* is *satisfactory* and *We* provide written notice of approval.

You must be *Actively at Work* for coverage under the Policy to become effective. If, because of *Injury* or *Sickness*, *You* are not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.

Noncontributory means the *Policyholder* pays 100% of the premium for this insurance.

00002

Who pays for Your coverage?

The *Policyholder* pays the entire cost of *Your* coverage.

00008

Do You have to pay premium while You receive benefits?

We will waive premium for *You* during a period of *Disability* for which the *LTD Monthly Benefit* is payable under the Policy. Premium payment is required during *Your Elimination Period* or any other period when the *LTD Monthly Benefit* is not payable under the Policy.

00009

LONG TERM DISABILITY BENEFITS

How do We define Total Disability?

Total Disability or ***Totally Disabled*** means that during the first 24 consecutive months of benefit payments due to *Sickness* or *Injury*;

1. *You* are continuously unable to perform the *Material and Substantial Duties of Your Regular Occupation*, and
 2. *Your Disability Earnings*, if any, are less than 20% of *Your pre-disability Indexed Monthly Earnings*.
- 00011

After the *LTD Monthly Benefit* has been paid for 24 consecutive months, ***Total Disability*** or ***Totally Disabled*** means that due to *Injury* or *Sickness*:

1. *You* are continuously unable to engage in any *Gainful Occupation*, and
 2. *Your Disability Earnings*, if any, are less than 20% of *Your pre-disability Indexed Monthly Earnings*.
- 00013

How do We define Partial Disability?

Partial Disability or ***Partially Disabled*** means that:

1. During the *Elimination Period* *You* are unable to perform all of the *Material and Substantial Duties of Your Regular Occupation*.
 2. During the first 24 consecutive months of benefit payments, due to *Injury* or *Sickness* *You* are unable to perform all of the *Material and Substantial Duties of Your Regular Occupation*, and *Your Disability Earnings*, if any, are at least 20% but less than or equal to 80% of *Your pre-disability Indexed Monthly Earnings*.
 3. After the *LTD Monthly Benefit* has been paid for 24 consecutive months ***Partial Disability*** or ***Partially Disabled*** means that due to *Injury* or *Sickness*, *You* are unable to engage in any *Gainful Occupation*; and *Your Disability Earnings*, if any, are at least 20% but less than or equal to 60% of *Your pre-disability Indexed Monthly Earnings*.
- 00014

Loss of Professional License or Certification

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability*.

00017

What is the Elimination Period and how is it satisfied?

The *Elimination Period* is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. It is shown in the *Schedule of Benefits* and begins on *Your Date of Disability*.

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than or equal to one-half the *Elimination Period* rounded up to the next whole number, not to exceed 90 days. The days that *You* are not *Disabled* will not count toward *Your Elimination Period*.

If *You* return to work for a period greater than one-half the *Elimination Period*, or 90 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period*.

00018

Can You satisfy Your Elimination Period if You are working?

You can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.

00019

What Disability Benefit are You eligible to receive?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1. an *LTD Monthly Benefit*;
2. a Work Incentive Benefit; or
3. Rehabilitation Incentive Income.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.

00020

What is Your LTD Monthly Benefit and how is it calculated?

Your LTD Monthly Benefit will be based on *Your Monthly Earnings* as reported to *Us* by the *Policyholder* and for which premium has been paid.

An *LTD Monthly Benefit* will be payable after the end of the *Elimination Period* if *You* are *Disabled*. We will calculate *Your Gross LTD Monthly Benefit* amount as follows:

1. Multiply *Your Monthly Earnings* by 66 2/3%.
2. The maximum *Gross LTD Monthly Benefit* is \$6,000.00.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit*.
4. Subtract the *Deductible Sources of Income* from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.
5. Compare the answer from item 3 and 4.

The lesser amount figured in item 5 is *Your Monthly Benefit*.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Net LTD Monthly Benefit* for each day of *Disability*.

00021-A

How do We define Monthly Earnings?

Monthly Earnings means *Your* gross monthly income from *Your Employer* in effect just prior to *Your Date of Disability*. It includes *Your* total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions, but does not include bonuses, overtime pay, or any other extra compensation, or income received from sources other than *Your Employer*.

Commissions will be averaged for the lesser of:

- a. the 12 full calendar month period of *Your* employment with *Your Employer* just prior to the date *Disability* begins; or
- b. the period of actual employment with *Your Employer*.

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

00022

What are the Deductible Sources of Income?

1. *Disability* benefits paid, payable, or for which *You* are eligible under:
 - a. The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;

- b. Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational Injury or Sickness;
 - c. Occupational accident coverage provided by or through the *Policyholder*;
 - d. Any Statutory Disability Benefit Law;
 - e. The Railroad Retirement Act;
 - f. The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
 - g. The Canada Old Age Security Act;
 - h. Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans;
 - i. Title 46, United States Code Section 688 et seq (The Jones Act);
 - j. Title 33, United States Code Section 901 et seq (Longshore and Harbor Workers' Compensation Act).
2. *Disability* benefits paid, payable, or for which You are eligible under:
 - a. Any group insurance plan provided by or through the *Policyholder* , and
 - b. Any sick leave or salary continuance plan provided by or through the *Policyholder* which causes the *Net Monthly Benefit*, plus Deductible Sources of Income and any salary continuation to exceed 100% of *Your* pre-disability *Indexed Monthly Earnings*. The amount in excess of 100% of *Your* pre-disability *Indexed Monthly Earnings* will be used to reduce *Your Net Monthly Benefit*.
 3. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;
 4. Retirement and *Disability* benefits paid under a Retirement Plan provided by the *Policyholder* except for amounts attributable to *Your* contributions;
 5. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;
 6. Amounts received from a third party after subtracting attorney's fees by judgment, settlement or otherwise, not to exceed 50% of the net settlement.

Proration of Lump Sum Awards

If any Deductible Source of Income described above is paid in a single sum through compromise settlement or as an advance on future liability, *We* will determine the amount of reduction to *Your Gross LTD Monthly Benefit* as follows:

1. *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or
2. If the number of months for which the settlement or advance is made is not known, *We* will divide the amount of the settlement or advance by the expected remaining number of months for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 60 months.

What other sources of income are not deductible?

We will not reduce *Your Gross LTD Monthly Benefit* by any of the following:

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2. credit disability insurance;
3. pension plans for partners;
4. military pension and disability income plans;
5. franchise disability income plans;
6. individual disability income plans;
7. a *Retirement Plan* from another *Policyholder*;

8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

00023

Can You work and still receive benefits?

While *Disabled*, *You* may qualify for the Work Incentive Benefit or Rehabilitation Incentive Income, but not both.

Work Incentive Benefit

A Work Incentive Benefit will be payable if *You* are *Disabled* and Gainfully Employed after the end of the *Elimination Period*, or after a period during which *You* received *LTD Monthly Benefits*.

The Work Incentive Benefit will be calculated during the first 12 months of disability payments while *You* are Gainfully Employed as follows:

1. We will add together the Gross *Monthly Benefit* and *Disability Earnings* and compare to pre-disability *Indexed Monthly Earnings*.
2. If the total amount in Item 1 exceeds 100% of pre-disability *Indexed Monthly Earnings*, the Work Incentive Benefit will be equal to the *LTD Monthly Benefit* reduced by the amount of the excess.
3. If the total amount in Item 1 does not exceed 100% of pre-disability *Indexed Monthly Earnings*, the Work Incentive Benefit will be equal to the *LTD Monthly Benefit* amount.

After the first 12 months of disability payments while *You* are *Disabled and Gainfully Employed*, the Work Incentive Benefit will be equal to the *Net Monthly Benefit* multiplied by the *Adjusted Loss of Salary Ratio*.

The Work Incentive Benefit will cease on the earliest of the following:

1. the date *You* are no longer *Disabled*; or
2. the end of the *Maximum Period Payable*.

Adjusted Loss of Salary Ratio is equal to: A divided by B

A= *Your pre-disability Indexed Monthly Earnings* minus *Your Disability Earnings*

B= *Your pre-disability Indexed Monthly Earnings*

Rehabilitation Incentive Income

Rehabilitation Incentive Income will be payable after the end of the *Elimination Period*, or after a period during which *You* received *LTD Monthly Benefits*. This benefit is payable if *You* are *Disabled and Gainfully Employed* in an occupation that has been approved as part of a *Rehabilitation Plan*.

Rehabilitation Incentive Income will be calculated during the first 12 months of *Gainful Employment* as follows:

1. If *Disability Earnings* exceed 100% of pre-disability *Indexed Monthly Earnings*, Rehabilitation Incentive Income will be equal to the *Net Monthly Benefit* reduced by the amount of the excess.
2. If *Disability Earnings* do not exceed 100% of pre-disability *Indexed Monthly Earnings*, Rehabilitation Incentive Income will be equal to the *Monthly Benefit*.

After the first 12 months of *Gainful Employment*, Rehabilitation Incentive Income will be equal to the *LTD Monthly Benefit* multiplied by the *Adjusted Loss of Salary Ratio*.

Rehabilitation Incentive Income will cease on the earliest of the following:

1. as stated in the *Rehabilitation Plan*;
2. the date *You* fail to comply with the requirements of the *Rehabilitation Plan*;

3. the date *You* are no longer *Gainfully Employed*; or
4. the end of the *Maximum Period Payable*.

Adjusted Loss of Salary Ratio is equal to: A divided by B

A= *Your* pre-disability *Indexed Monthly Earnings* minus *Your Disability Earnings*

B= *Your* pre-disability *Indexed Monthly Earnings*

00024-A

What is the minimum Net LTD Monthly Benefit payable under the Policy?

The *Net LTD Monthly Benefit* payable for *Disability* will not be less than \$100.00 or 10% of *Your Gross LTD Monthly Benefit*, whichever is greater. The minimum Net LTD Monthly Benefit does not apply if *You* are *Gainfully Employed*

00025

What happens if Your Deductible Sources of Income increase?

The *Net LTD Monthly Benefit* will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which *You* or *Your* dependents are eligible under any *Deductible Source of Income* shown above.

00026

How long will You receive benefits under the Policy?

We will send *You* a payment for each month of *Disability* up to the *Maximum Period Payable* as shown in the *Schedule of Benefits*. Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.

00027

What happens if Your Disability recurs?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 6 months after the end of a prior *Disability* is subject to:

1. a new *Elimination Period*;
2. a new *Maximum Period Payable*; and
3. the other provisions of the Policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the Policy.

00028

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

The Policy does not cover any loss or *Disability* caused by, resulting from, arising out of or substantially contributed, directly or indirectly, to by any one or more of the following:

- *a Pre-Existing Condition*;
- commission of, participation in, or an attempt to commit an assault or felony;
- Intentionally self-inflicted injuries;
- attempted suicide, regardless of mental capacity;
- participation in a war, declared or undeclared, or any act of war;
- active military duty;
- active *Participation in a Riot*;
- commission of a crime for which *You* have been convicted;

The *Policy* has limitations on:

- *Mental Disorder - Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit.
- *Substance Abuse* – A *Substance Abuse* (drug or alcohol) related *Disability* unless *You* are participating in a *Substance Abuse* treatment program approved by the State where the treatment program is provided. The cost of the treatment program must be borne by *You* or another group plan of the *Policyholder* (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

Except as specifically stated above, in no event will *LTD Monthly Benefits* for a *Mental Disorder* or *Substance Abuse* be paid beyond the earliest of the date:

1. 24 *LTD Monthly Benefit* payments have been made; or
2. the *Maximum Period Payable* is reached; or
3. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
4. *You* are no longer following the requirements of *Your* treatment plan under the program; or
5. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

The lifetime cumulative *Maximum Period Payable* for all disabilities due to a *Mental Disorder* and *Substance Abuse* is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

1. are not continuous; and/or
2. are not related.

Furthermore:

- Benefits are not payable during the first 24 months of *LTD Monthly Benefits*, when *You* are able to return to work in *Your Regular Occupation* on a part-time basis but *You* do not.
- Benefits are not payable after 24 months of *LTD Monthly Benefits*, when *You* are able to work in any *Gainful Occupation* on a part-time basis but *You* do not.

00029-ND

TERMINATION OF COVERAGE

When will Your insurance terminate?

Your coverage will terminate on the earliest of the following dates:

1. the date on which the Policy is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the date on which the Employer's participation under the Policy is terminated; or
4. the date *You*:
 - a. are no longer a member of a class eligible for this insurance,
 - b. request termination of coverage under the Policy,
 - c. are retired or pensioned, or
 - d. cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the *Policyholder* have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began while the coverage was in force.

00030

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the *Policyholder* approves a leave under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the required premium according to the terms of the Policy; and
2. coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the *Policyholder*.

00031

Will coverage be continued if You are eligible for leave under USERRA?

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

1. the length of time the coverage may be continued under the Certificate for an FMLA or State FML leave of absence; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a leave of absence other than an FMLA or State FML leave of absence.

00032

Will coverage be continued for other leaves of absence?

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

If the *Policyholder* has approved more than one type of leave of absence for *You* during any one period that *You* are not *Actively at Work* *We* will consider such leaves to be concurrent for the purpose of determining how long *Your* coverage may continue under the Policy.

If *Your* coverage is not continued during an FMLA or State FML leave of absence, and *You* become *Actively at Work* immediately following the end of *Your* FMLA or State FML leave of absence, *Your* coverage will be reinstated. *We* will not apply a new *Waiting Period*, require *Evidence Of Insurability*, or apply a new *Pre-existing Condition* limitation.

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

In no event will *Your* coverage under the policy be continued beyond the date *Your* coverage would otherwise end according to the terms of the *When will Your insurance terminate?* provision.

00033

DAY CARE EXPENSE BENEFIT

Are Day Care Expense Benefits available while You are Disabled?

While *Disabled* and receiving Rehabilitation Incentive Income, *You* will be reimbursed for *Day Care Expenses* for each *Eligible Child*. *You* must supply satisfactory proof to *Us* that *You* incurred such charges.

Day Care Expenses mean monthly expenses, up to \$350.00 per child per month, to a maximum total benefit of \$1,000.00 per month, charged by a licensed day care provider who is not a member of *Your* immediate family or living in *Your* residence.

Eligible Child means *Your Dependent Child* under age 13 who lives with *You*.

Dependent Child(ren) means any unmarried child of *Yours*, whether natural, step, foster or adopted, who is primarily dependent on *You* for financial support and maintenance.

The Day Care Expense Benefit payments will end the earliest of the following to occur:

1. the date *You* are no longer incurring *Day Care Expenses* for your *Eligible Child*;
2. the date *You* are no longer receiving Rehabilitation Incentive Income;
3. after 12 monthly Day Care Expense Benefit payments have been made for each *Eligible Child*

00034

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

We will pay a Survivor Income Benefit to an *Eligible Survivor* when proof is received that *You* died:

1. After the Disability had continued for 6 or more consecutive months; and
2. While receiving an *LTD Monthly Benefit*

The Survivor Income Benefit shall be payable on a lump sum basis immediately after *We* receive written proof of *Your* death. The benefit will be equal to 3 times *Your Last Monthly Benefit*. The benefit shall accrue from *Your* date of death.

Eligible Survivor means *Your Spouse*, if living, or if *Your Spouse* dies before the final monthly benefit is paid, then *Your* children who are under age 23.

If payment becomes due to *Your* children, payment will be made to:

1. the children; or
2. a person named by *Us* to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

Last Monthly Benefit means the *Monthly Benefit* paid to *You* immediately prior to *Your* death, but not including any reductions for *Deductible Sources of Income*.

If there is no *Eligible Survivor*, *We* will pay the Survivor Income Benefit to *Your* estate.

00036

REHABILITATION BENEFIT

What is the Rehabilitation Benefit?

If *You* are receiving a *Monthly Benefit* and *You* are participating in a *Rehabilitation Plan* approved by *Us*, *You* will receive a monthly *Rehabilitation Benefit*. The *Rehabilitation Benefit* pays 5% of *Your Gross LTD Monthly Benefit* to a maximum of \$500.00 per month subject to the maximum *Monthly Benefit* as shown in the *Schedule of Benefits*.

Eligibility for a *Rehabilitation Plan* is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for a *Rehabilitation Plan*:

1. *Your Disability* must prevent *You* from performing *Your Regular Occupation*;
2. *You* must have the physical and/or mental capacities necessary for successful completion of a *Rehabilitation Plan*; and
3. there must be a reasonable expectation that the *Rehabilitation Plan* will help *You* return to *Gainful Employment*.

The *Rehabilitation Benefit* is not subject to policy provisions which would otherwise increase or reduce the *Monthly Benefit*.

Rehabilitation Benefit payments will end on the earliest of the following dates:

1. after 6 monthly *Rehabilitation Benefit* payments have been made;
2. on the date *We* determine that *You* are no longer eligible to participate in a *Rehabilitation Plan*;
3. on the date *You* are no longer participating in the *Rehabilitation Plan*; or
4. on any other date monthly payments would cease in accordance with the *Policy*.

00039

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

We will assist *You* and the *Policyholder* in identifying modifications *We* agree are likely to help *You* remain at work or return to work. This agreement will be in writing and must be signed by *You*, the *Policyholder* and *Us*.

When this occurs, *We* will reimburse the *Policyholder* for the cost of the modification, up to the greater of:

1. \$1,500.00; or
2. 2 times *Your Last Monthly Benefit*.

We will reimburse the *Policyholder* upon completion of the following:

1. agreed upon modifications made on *Your* behalf are completed;
2. written proof of expenses incurred by *Your Policyholder* have been provided to *Us*; and
3. *You* have returned to work and are an *Actively at Work Employee*.

Last Monthly Benefit means the monthly benefit paid to *You* immediately prior to *Your* request for benefits under the Worksite Modification Benefit provision, but not including any reductions for *Deductible Sources of Income*.

00044

CLAIM SERVICES

What other services are available to You while You are Disabled?

If *You* are *Disabled* and eligible to receive *Disability* benefits under the Policy, *We* will evaluate *You* for eligibility to receive any of the following. *We* will make the final determination for any of the following benefits or services.

Vocational Rehabilitation Service

Rehabilitation services are available when *We* determine that these services are reasonably required to assist in returning *You* to *Gainful Employment*. Vocational rehabilitation services might include but are not limited to one or more of the following:

1. job modification;
2. job retraining;
3. job placement;
4. other activities.

Eligibility for vocational rehabilitation services is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

1. *Your* Disability must prevent *You* from performing *Your Regular Occupation*;
2. *You* must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
3. there must be a reasonable expectation that rehabilitation services will help *You* return to *Gainful Employment*.

Social Security Disability Assistance

When necessary, *We* will provide an advocate for *You* in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.

00047

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The *Policyholder* can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the *Policyholder* and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the *Proof of Disability* provision.

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is shown in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1. It was not reasonably possible to give written proof during the 1 year period, and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to provide complete proof of loss may delay, suspend or terminate *Your* benefits.

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;
4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your Monthly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8. If *You* were contributing to the premium cost, the *Policyholder* must supply proof of *Your* appropriate payroll deductions.
9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of Disability

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be made as often as reasonably necessary. If required, this will be at *Your* expense and must be received within 45 days of *Our* request. Failure to comply with such a request may delay, suspend or terminate *Your* benefits.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may result in denial, suspension or termination of benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information in support of *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2. *You* will be required to supply proof that *You* have applied for other Deductible Sources of Income such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Sources of Income. *You* must tell *Us* the nature of the Deductible Source of Income, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

00048

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit on a monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; or 4) *Your* estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to \$1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

00049

Can *You* assign *Your* benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs. The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.

We have the right to recover from *You* any amount that is an overpayment of benefits under the Policy. *You* must refund to us the overpaid amount. *We* may also, without forfeiting our right to collect an overpayment through any means legally available to *Us*, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the *Minimum Monthly Benefit*.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *LTD Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *LTD Monthly Benefits* payable under the Policy.

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*. *We* will bear any expenses associated with *Our* pursuit of subrogation or recovery.

00050

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the *Policyholder's* application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the *Policyholder* and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the Policy will make it void unless the representation is contained in the signed application; or
2. any *Employee* in applying for insurance under the Policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the *Employee*, is or has been given to the *Employee*.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against *Us*:

1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Misstatement of Age

If *Your* age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon *Your* age, as shown in the Benefit Duration Schedule, the amount of the benefit will be the amount *You* would have been entitled to if *Your* correct age were known.

Note: A refund of premium will not be made for a period more than twelve months before the date the Company is advised of the error.

Incontestability

The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the Policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the Policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Conformity with State Statutes and Regulations

If any provision of the Policy conflicts with the statutes and regulations of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

Workers' Compensation or State Disability Insurance

The Policy is not in place of, and does not affect the requirements for coverage by any workers' compensation or state disability insurance.

Agency

Neither the *Policyholder*, any employer, any associated company, nor any administrator appointed by the foregoing is *Our* agent.

General Provisions

We have the right to inspect all of the *Policyholder's* records on the Policy at any reasonable time. This right will extend until:

1. 2 years after termination of the Policy; or
2. all claims under the Policy have been settled,

whichever is later.

The Policy is in the *Policyholder's* possession and may be inspected by *You* at any time during normal business hours at the *Policyholder's* office.

00051

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.

00052

Actively at Work or ***Active Work*** means that *You* must be:

1. working for the *Policyholder* on a full-time active basis; or
2. working at least the minimum number of hours shown in the Schedule of Benefits; and either:
 - a. working at the *Policyholder's* usual place of business; or
 - b. working at a location to which the *Policyholder's* business requires *You* to travel;
3. a legal citizen or resident of the United States of America;
4. are paid regular earnings by the *Policyholder*, and
5. not a temporary or seasonal *Employee*.

You will be considered ***Actively at Work*** if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave).

00053

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain maximum medical improvement.

00055

Date of Disability is the date *We* determine that *You* are *Disabled*.

00057

Disability or ***Disabled*** means that *You* satisfy the definition of either Total Disability or Partial Disability.

00058

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes any earnings *You* could receive if *You* were working to *Your Maximum Capacity*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

If *Your Disability Earnings* routinely fluctuate widely from month to month, *We* may average *Your Disability Earnings* over the most recent three months to determine if *Your* claim should continue. If *We* average *Your Disability Earnings*, *We* will not terminate *Your* claim unless the average of *Your Disability Earnings* from the last three months exceeds 80% of *Your Indexed Monthly Earnings*.

00059

Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You*, similar to that of a *Spouse*, as evidenced by the following:

1. *You* and *Your Domestic Partner* share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. *You* and *Your Domestic Partner* each are at least eighteen (18) years of age;
3. *You* and *Your Domestic Partner* are both mentally competent to enter into a binding contract;
4. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and

Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

Where the laws of the governing jurisdiction mandate a definition of *Domestic Partner* other than shown above, that definition will be used in the Policy.

00060

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.

00061

Elimination Period means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.

00062

Employee means an *Actively at Work* full-time *Employee* whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, who is *Actively at Work* for at least the number of hours per week as stated in the Application and is reported on the *Policyholder's* records for Social Security and withholding tax purposes.

00069

Gainful Occupation, Gainful Employment or Gainfully Employed means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis.

00063

Generally Accepted Medical Practice or Generally Accepted in the Practice of Medicine means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

00064

Gross LTD Monthly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.

00065

Hospital or Health Care Facility is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.

00066

Indexed Monthly Earnings means *Your Monthly Earnings* adjusted on each anniversary of benefit payment by the lesser of 7% or the current annual percentage increase in the *Consumer Price Index*. *Your Indexed Monthly Earnings* may increase or remain the same, but will never decrease.

Consumer Price Index (CPI-W) means the Consumer Price Index for all urban wage earners and clerical workers in the United States as published by the Bureau of Labor Statistics of the United States Department of Labor or its successors. If the CPI-W is discontinued or changed, *We* may use another index that most closely reflects the cost of living in the United States.

Indexing is only used as a factor in the determination of the percentage of lost earnings while *You* are *Disabled* and working in a *Gainful Occupation*.

00067a

Injury means bodily injury that is the direct result of an *Accident* and not related to any other cause. The *Injury* must occur, and *Disability* resulting from the *Injury* must begin while *You* are covered under the *Policy*. *Injury* that occurs before *You* are covered under the *Policy* will be treated as a *Sickness*.

00068

LTD means Long Term Disability.

00070

Male pronoun, whenever used, includes the female.

00071

Material and Substantial Duties means duties that:

1. are normally required for the performance of *Your Regular Occupation*; and
2. cannot be reasonably omitted or modified, except that if *You* are required to work on average in excess of 40 hours per week, *We* will consider *You* able to perform that requirement if *You* have the capacity to work 40 hours.

00072

Maximum Capacity means, based on *Your* restrictions and limitations:

1. During the first 24 consecutive months of *monthly payments*, the greatest extent of work *You* are able to do in *Your Regular Occupation*; and
2. Beyond 24 consecutive months of *monthly payments*, the greatest extent of work *You* are able to do in any *Gainful Occupation*.

00073

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.

00074

Maximum Period Payable, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.

00075

Mental Disorder means a disorder found in the current diagnostic standards of the American Psychiatric Association.

00076

Monthly Benefit means the LTD Monthly Benefit shown in the *Schedule of Benefits* which applies to *You*.

00077

Monthly Earnings means *Your* gross monthly income from *Your Employer* in effect just prior to *Your Date of Disability*. It includes *Your* total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions, but does not include bonuses, overtime pay, or any other extra compensation, or income received from sources other than *Your Employer*.

Commissions will be averaged for the lesser of:

- c. the 12 full calendar month period of *Your* employment with *Your Employer* just prior to the date *Disability* begins; or
- d. the period of actual employment with *Your Employer*.

00078

Net LTD Monthly Benefit means the *Gross LTD Monthly Benefit* less the Deductible Sources of Income.

00079

Participation in a Riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

00080

Pre-existing Condition means a condition which;

1. was caused by, or results from a *Sickness* or *Injury* for which *You* received medical treatment, or advice was rendered, prescribed or recommended within 3 months prior to *Your* effective date; and
2. results in a Disability which begins in the first 12 months after *Your* effective date.

00081-ND

Regular Occupation means the occupation that *You* are routinely performing when *Your Disability* begins. We will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location.

00082

Rehabilitation Plan means a written agreement between *You* and *Us*. Its purpose is to assist *You* in returning to *Gainful Employment*. The *Rehabilitation Plan* will outline the time and dates of the vocational rehabilitation services, *Our* responsibilities, *Your* responsibilities and the responsibilities of any third party which might be involved. The *Rehabilitation Plan* will be at *Our* expense, at the expense of the third party, or a shared expense of *Ours* and a third party. At *Our* discretion, the *Rehabilitation Plan* will include the Day Care Expense Benefit.

00083

Riot shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

00085

Schedule of Benefits means the schedule which is a part of this certificate.

00086

Sickness means sickness or disease causing *Disability* which begins while *You* are covered under the Policy.

00087

Spouse means lawful spouse in the jurisdiction in which *You* reside. *Spouse* will include *Your Domestic Partner*.

00091

Substance Abuse means a pattern of pathological use of alcohol or other psychoactive drugs resulting in impairment of social and or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the substance, or the need for daily substance use for adequate functioning.

00092

Waiting Period as shown in the Schedule of benefit means the continuous length of time immediately before *Your* Effective Date during which *You* must be in an Eligible Class. Any period of time prior to the Policy Effective Date *You* were Actively at Work for *Your* Employer will count towards completion of the Waiting Period.

00093

We, Our and **Us** mean the Dearborn National Life Insurance Company, Chicago, Illinois.

00094

You, Your and **Yours** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.

00095



Administrative Office:
1020 31st Street • Downers Grove, IL 60515-5591

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