

MONTGOMERY COUNTY



Request for Proposal (RFP)# 16-25  
for  
Long Term Disability Services  
Issue Date: January 20, 2016  
Proposal Due Date and Hour: February 10, 2016 3:00  
p.m.

Montgomery County Purchasing Department  
755 Roanoke Street, Suite 2C  
Christiansburg, VA 24073-3179

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Long Term Disability Services

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COUNTY OF MONTGOMERY, VIRGINIA  
RFP # 16-25

ISSUE DATE: JANUARY 20, 2016

Long Term Disability Services  
(TO BE COMPLETED AND RETURNED)  
**GENERAL INFORMATION FORM**

**QUESTIONS:** All inquiries for information regarding this solicitation should be directed to: Heather M. Hall, C.P.M., Procurement Manager, Phone: (540) 382-5784; faxed to (540) 382-5783, or e-mail: [hallhm@montgomerycountyva.gov](mailto:hallhm@montgomerycountyva.gov)

**DUE DATE:** Sealed Proposals will be received until **February 10, 2016**, up to and including **3:00PM**. Failure to submit proposals to the correct location by the designated date and hour will result in disqualification.

**ADDRESS:** Proposals should be mailed or hand delivered to: **Montgomery County Purchasing Department, 755 Roanoke Street, Suite 2C, Christiansburg, Virginia 24073-3179**. Reference the Due Date and Hour, and RFP number in the lower left corner of the return envelope or package.

**COMPANY INFORMATION/SIGNATURE:** In compliance with this Request For Proposal and to all conditions imposed herein and hereby incorporated by reference, the undersigned offers and agrees to furnish the services and goods in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Full Legal Name (print)		Federal Taxpayer Number (ID#)	Contractor's Registration
Business Name / DBA Name / TA Name and Address		Payment Address	Purchase Order Address
Contact Name/Title		Signature (ink)	Date
Telephone Number	Fax Number	Toll Free Number	E-mail Address

**COUNTY OF MONTGOMERY**  
**RFP# 16-25**  
Long Term Disability Services

**I PURPOSE:** The intent and purpose of this Request for Proposal (RFP) is to establish a contract through competitive negotiation for Long Term Disability Services for the County of Montgomery, Virginia herein after referred to as “County.” The effective date of the contract is April 1, 2016.

**II BACKGROUND:**

The County is the fiscal agent for the following entities:

- Montgomery County Public Service Authority
- Montgomery County Department of Social Services
- Montgomery/Floyd Regional Library
- NRV911 Regional Authority will be their own entity effective 7/1/16

These entities and all of their full time employees participate in the County’s Long Term Disability Plan. Any reference to the County in this RFP includes the above related entities. The Employee Census (Attachment C) includes employees of the above entities.

**III STATEMENT OF NEED:**

- A. Benefit Plan History:** Montgomery County has been insured with Dearborn National for the past five years for its long term disability coverage. It is the intent of the County to continue to offer a program with similar benefit levels as the current plan.
- B. Current Benefit Plans**
- 1. Long Term Disability**  
Plan design must be clearly stated in the proposal. Offerors are encouraged to offer options to improve plan design and/or lower cost.
- 2. Other Plan Benefits**  
Montgomery County provides life insurance through the Virginia Retirement System. Coverage for Health Insurance is currently carried by Anthem. Neither of these coverage’s are included in this RFP. We would like to view the following voluntary payroll deductible plans:  
-Critical illness/accident  
-ability to buy up LTD to 66 2/3 %
- C. Employer Contribution:** Montgomery County currently pays 100% of premiums for all full time employees. Part time employees are not eligible for the LTD program.
- D. Financial Design:** Montgomery County requests proposals on a guaranteed cost, prospectively rated basis. This is not an RFP for a Cafeteria plan.
- E. Long Term Cost Projections and Rate Guarantees:** Multiple year rate guarantees or caps on rate of increase for the 2<sup>nd</sup> year and future years are desired and will be part of the evaluation process. Offerors should clearly indicate the average rate of premium increase for 2<sup>nd</sup> and 3<sup>rd</sup> year subscribers.
- F. Census of Employees and Job Classification Codes:** Enclosed is a census to be used in preparing the proposal (Attachment C).
- G. Claims and Premium History:** Claims history for the past 5 years is attached (Attachment D). Also included are total premium figures of the current and previous years as of December 2015.
- H. Participation Requirements, Preexisting Conditions and Underwriting:** Offerors are to clearly state preexisting condition or exclusionary requirements. All current and future subscribers must be accepted by the offeror. No individual medical screening or underwriting is desired by Montgomery County. Minimum participation requirements must also be shown. Due to the employer contribution, participation has always been 100% of full time employees.
- I. Monthly Payroll and Rates:** Average payroll over the last six months is \$1,349,351.83 and the rate is \$0.33 per month for \$100 of covered payroll. Proposers should use the above monthly payroll as the basis for their proposal. Rates between classes of employees are currently blended. For simplicity of administration, blended rates are desired but not mandatory.
- J. Definition of Full Time Employee and Waiting Period:** Individuals working 40 hours or more a week are eligible for county paid benefits. Enrollment into the plan of new employees as the first of the month following the date of employment.

K. **Administration and Claims Service:** Offerors must clearly explain where claims are processed and availability of toll free numbers.

L. **Best's Key Rating:** Show the Best's Key Rating for each company listed in the proposal.

#### **IV PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS:**

##### **A. GENERAL REQUIREMENTS:**

1. **RFP Response:** In order to be considered for selection, Offerors must submit a complete response to this RFP. One (1) original and four (4) copies of each proposal are required. You may elect to submit the copies as electronic documents in Word or PDF format to [hallhm@montgomerycountyva.gov](mailto:hallhm@montgomerycountyva.gov) or on CD or jump drive with the proposal package. If you send all hard copies, each copy of the proposal should be bound or contained in a single volume where practical. All documentation submitted with the proposal should be contained in that single volume. No other distribution of the proposal shall be made by the Offeror. All proposals must be submitted to:

Heather M. Hall, C.P.M., Procurement Manager  
Montgomery County Purchasing Department  
755 Roanoke Street, Suite 2C  
Christiansburg, VA 24073-3179

Identify on outside of envelope: **Sealed RFP # 16-25**

RFP Due date/Opening date and hour: **February 10, 2016, 3:00 P.M.**

The Offeror shall make no other distribution of the proposal.

##### **2. Proposal Preparations:**

- a. Proposal shall be signed by an authorized representative of the Offeror. All information requested should be submitted. The Procurement Manager will review all proposals to ensure required information is included. Failure to submit all information requested may result in a request to submit the missing information. Proposals which are substantially incomplete or lack key information may be rejected as incomplete. Mandatory requirements are those required by law or regulation or are such that they cannot be waived and are not subject to negotiation.
- b. Proposals will be reviewed and evaluated by a Committee as designated by the County.
- c. Proposal should be prepared simply and economically, providing a straight forward, concise description of capabilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.
- d. Proposals should be organized in the order in which the requirements are presented in the RFP. All pages of the proposal should be numbered. Each paragraph in the proposal should reference the paragraph number of the corresponding section of the RFP. It is also helpful to cite the paragraph number, subletter, and repeat the text of the requirements as it appears in the RFP. If a response covers more than one page. The proposal should contain a table of contents which cross references the RFP requirements. Information which the offeror desires to present that does not fall within any of the requirements of the RFP should be inserted at an appropriate place or be attached at the end of the proposal and designated as additional material. Proposals that are not organized in this manner risk elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed.
- e. Each copy of the proposal should be bound or contained in a single volume where practical. All documentation submitted with the proposal should be contained in that single volume.
- f. Ownership of all data, materials and documentation originated and prepared for the County pursuant to the RFP shall belong exclusively to the County and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an Offeror

shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of Section 2.2-4342D of the Code of Virginia, in writing, either before or at the time the data or other materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and will result in rejection of the proposal.

**B. SPECIFIC REQUIREMENTS:** Proposals should be as thorough and as detailed as possible so that the County may properly evaluate your capabilities to provide the required services. Offerors are required to submit the following information/items as a complete proposal:

1. The return of the RFP general information form and addenda, if any, signed and completed as required.
2. Please provide four (4) recent references, similar to Montgomery County, for whom you have provided the type of services described herein. Include the date(s) services were furnished, the client name, address and the name, phone number and email address of the individual Montgomery County has your permission to contact.
3. Describe the Offerors ability to provide superior administrative and claims service.
4. Fully describe all coverage terms and conditions of the benefit plan being offered. Coverage terms must include a minimum benefit of at least 60% of monthly earnings with a maximum gross monthly benefit no lower than \$5,000.00.
5. Discuss initial rates and projected long term cost and rate guarantees. To be competitive, is your company willing to provide a longer rate guarantee?
6. Briefly indicate the main attributes that differentiate your company from your competitors.
7. Provide evidence of financial security of insurer such as Best's, Moody's or S&P Rating.

**V. EVALUATION AND AWARD OF CONTRACT:**

**A. Award of Contract:** Selection shall be made of two or more offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposal, including price, if so stated in the Request for proposal. Negotiations shall be conducted with the offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each offeror so selected, Montgomery County shall select the offeror which, in its opinion, has made the best proposal, and shall award the contract to that offeror. Montgomery County may cancel the Request for Proposal or reject proposals at any time prior to an award, and is not required to furnish a statement of the reason why a particular proposal was not deemed to be the most advantageous. (Section 2.2-4359D, Code of Virginia.) Should Montgomery County determine in writing and in its sole discretion that only one offeror is fully qualified, or that one offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that offeror. The award document will be a contract incorporating by reference all the requirements, terms, and conditions of the solicitation and the contractor's proposal as negotiated. See Attachment B for sample contract form.

**B. Evaluation Criteria:** Proposals shall be evaluated by the County using the following criteria:

<u>EVALUATION CRITERIA</u>	<u>WEIGHT</u>
1. Coverage terms and conditions of the benefit plan	35
2. Initial and projected long term cost and rate guarantees	35

- 3. Experience providing similar services to public bodies similar in size to Montgomery County 15
- 4. Financial security of insurer 15

**VI CONTRACT ADMINISTRATION:**

Ciara Price, Benefits Coordinator, or her designee, shall be identified as the Contract Administrator and shall use all powers under the contract to enforce its faithful performance. The Contract Administrator, or her designee, shall determine the amount, quantity, acceptability, fitness of all aspects of the services and shall decide all other questions in connection with the services. The Contract Administrator, or her designee, shall not have the authority to approve changes in the services which alter the concept or which call for an extension of time for this contract. Any modifications made must be authorized by the Montgomery County Purchasing Department through a written amendment to the contract.

**VII PAYMENT PROCEDURES:** The County will authorize payment to the Contractor after receipt of Contractor's correct invoice for services rendered. Invoices shall be sent to:

Montgomery County Human Resources  
Attn: Ciara Price  
755 Roanoke Street, Suite 2D  
Christiansburg, VA 24073-3180

**VIII CONTRACT PERIOD:** The term of this contract is for one year or as negotiated. There will be an option for four (4) one-year renewals or as negotiated. This is assuming a satisfactory service, rate guarantees and renewal quotations are acceptable as negotiated by the County. The effective date of this contract is April 1, 2016.

**ATTACHMENT A  
TERMS AND CONDITIONS**

**GENERAL TERMS AND CONDITIONS**

[http://www.montgomerycountyyva.gov/filestorage/16277/16344/16633/16661/RFP\\_terms\\_and\\_conditions.pdf](http://www.montgomerycountyyva.gov/filestorage/16277/16344/16633/16661/RFP_terms_and_conditions.pdf)

**SPECIAL TERMS AND CONDITIONS**

1. **AUDIT:** The Contractor hereby agrees to retain all books, records, and other documents relative to this contract for five (5) years after final payment, or until audited by the Commonwealth of Virginia, whichever is sooner. Montgomery County, its authorized agents, and/or State auditors shall have full access to and the right to examine any of said materials during said period.
2. **AUTHORIZED USERS:** Additional State agencies, institutions and/or other public bodies may be added or deleted to receive the goods or services resulting from this solicitation. The addition or deletion of authorized users shall be made only by written modification to the contract. Such modification shall name the specific agency added or deleted and the effective date.
3. **AVAILABILITY OF FUNDS:** It is understood and agreed between the parties herein that Montgomery County shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.
4. **CANCELLATION OF CONTRACT:** Montgomery County reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 60 days written notice to the Contractor. In the event the initial contract period is for more than 12 months, the resulting contract may be terminated by either party, without penalty, after the initial 12 months of the contract period upon 60 days written notice to the other party. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.
5. **IDENTIFICATION OF PROPOSAL ENVELOPE:** The signed proposal should be returned in a separate envelope or package, sealed and addressed as follows:  
Montgomery County  
Purchasing Department  
755 Roanoke Street, Suite 2C  
Christiansburg, VA 24073-3179  
Reference the opening date and hour, and RFP Number in the lower left corner of the envelope or package.  
If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. No other correspondence or other proposals should be placed in the envelope. Proposals may be hand delivered to the Montgomery County Purchasing Department.
6. **INDEPENDENT CONTRACTOR:** The contractor shall not be an employee of Montgomery County, but shall be an independent contractor. Nothing in this agreement shall be construed as authority for the contractor to make commitments which shall bind Montgomery County, or to otherwise act on behalf of Montgomery County, except as Montgomery County may expressly authorize in writing.
7. **INSURANCE:**  
By signing and submitting a proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the work commences. Additionally, it will maintain these during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.  
During the period of the contract, Montgomery County reserves the right to require the Contractor to furnish certificates of insurance for the coverage required.  
**INSURANCE COVERAGES AND LIMITS REQUIRED:**
  - A. Worker's Compensation - Statutory requirements and benefits.
  - B. Employers Liability - \$100,000.00
  - C. General Liability - \$500,000.00 combined single limit. Montgomery County and the Commonwealth of Virginia shall be named as an additional insured with respect to goods/services being procured. This coverage is to include Premises/Operations Liability, Products and Completed Operations Coverage, Independent Contractor's Liability, Owner's and Contractor's Protective Liability and Personal Injury Liability.
  - D. Automobile Liability - \$500,000.00The contractor agrees to be responsible for, indemnify, defend and hold harmless Montgomery County, its officers, agents and employees from the payment of all sums of money by reason of any claim against them arising out of any and all occurrences resulting in bodily or mental injury or property damage that may happen to occur in connection with and during the performance of the contract, including but not limited to claims under the Worker's Compensation Act. The contractor agrees that it will, at all times, after the completion of the work, be responsible for, indemnify, defend and hold harmless Montgomery County, its officers, agents and employees from all liabilities resulting from bodily or mental injury or property damage directly or indirectly arising out of the performance or nonperformance of the contract.
8. **MINORITY BUSINESS, WOMEN-OWNED BUSINESSES SUBCONTRACTING AND REPORTING:** Where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such business to minority and/or women-owned businesses. Names of firms may be available from the buyer and/or from the Division of Purchases and Supply. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted and type of product/service provided.
9. **SUBCONTRACTS:** No portion of the work shall be subcontracted without prior written consent of Montgomery County. In the event that the Contractor desires to subcontract some part of the work specified herein, the Contractor shall furnish Montgomery County the names, qualifications and experience of their proposed subcontractors. The Contractor shall, however, remain fully liable and responsible for the work to be done by his subcontractor(s) and shall assure compliance with all requirements of the contract.

**ATTACHMENT B  
COUNTY OF MONTGOMERY  
STANDARD CONTRACT**

**Contract Number:**

This contract entered into this \_\_\_ day of, 201\_\_, by \_\_\_\_\_ hereinafter called the “Contractor” and the County of Montgomery, called the “County”.

**WITNESSETH** that the Contractor and the County, in consideration of mutual covenants, promises and agreements herein contained, agree as follows:

**SCOPE OF SERVICES:** The Contractor shall provide the services to the County as set forth in the Contract Documents.

**CONTRACT PERIOD:** The initial contract period is \_\_\_\_\_ through \_\_\_\_\_.

**COMPENSATION AND METHOD OF PAYMENT:** The Contractor shall be paid in accordance with the Contract Documents.

**CONTRACT DOCUMENTS:** The Contract Documents shall consist of signed Contract, the statement of need, general terms and conditions, special terms and conditions, specifications, and other data contained in this Request For Proposal Number, dated \_\_\_\_\_, together with all written modifications thereof, the proposal submitted by the Contractor dated \_\_\_\_\_ and the Contractor’s letter dated \_\_\_\_\_, all of which contract documents are incorporated herein.

In **WITNESS WHEREOF**, the parties have caused this Contract to be duly executed intending to be bound thereby.

**CONTRACTOR:**

**COUNTY OF MONTGOMERY:**

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

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

# Group Long Term Disability Insurance

*Employee Benefit Booklet*



**MONTGOMERY COUNTY, VIRGINIA**

**FAE10189-0001**

**Class 1-01**

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn 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, Puerto Rico and Guam.

**04/22/2011**

# FORT DEARBORN LIFE Insurance Company®

## Group Certificate

Fort Dearborn Life Insurance Company

Chicago, Illinois

Administrative Office: 1020 31<sup>st</sup> Street • Downers Grove, IL 60515

Having issued Group Policy No. **FAE10189-0001**

(herein called the Policy or this Plan)

to

**MONTGOMERY COUNTY, VIRGINIA**

(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 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 Fort Dearborn Life Insurance Company



Secretary



President

### Group Long Term Disability Certificate

Non-Participating

**THIS IS NOT A WORKERS' COMPENSATION CERTIFICATE**

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Note: All terms in *Italics* are listed and defined in the Definitions section or within the certificate itself.

<b>SCHEDULE OF BENEFITS</b>
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<i>Policyholder:</i>	MONTGOMERY COUNTY, VIRGINIA
Policy Number:	FAE10189-0001
Effective Date:	April 1, 2011
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: First of the month following 90 Days of continuous, full-time active work</p> <p>If <i>You</i> enter a class eligible for insurance after the Policy Effective Date: First of the month following 90 Days of continuous, full-time active work</p>
Elimination Period:	90 Days
LTD Monthly Benefit:	60% of <i>Monthly Earnings</i> to a <i>Maximum Gross Monthly Benefit</i> of \$5,000.00 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:	<b>Age on Date Disability Commences</b>	<b>Maximum Period Payable</b>
	Less than 60	To Retirement Age
	60	60 months or to Retirement Age*, whichever is longer
	61	48 months or to Retirement Age*, whichever is longer
	62	42 months or to Retirement Age*, whichever is longer
	63	36 months or to Retirement Age*, whichever is longer
	64	30 months or to Retirement Age*, whichever is longer
	65	24 months or to Retirement Age*, whichever is longer
	66	21 months or to Retirement Age*, whichever is longer
	67	18 months or to Retirement Age*, whichever is longer
	68	15 months or to Retirement Age*, whichever is longer
	69 or over	12 months or to Retirement Age*, whichever is longer

\* 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.

<b>Year of Birth</b>	<b>Social Security Normal Retirement Age</b>
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
- Continuity of Coverage

**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.

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### ***Who pays for Your coverage?***

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

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### ***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.

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### ***What happens if We are replacing an existing Policy?***

#### ***Effect on Actively at Work requirement***

If *You* were insured under the *Prior Policy* on the day before the Policy Effective Date, *You* may be covered by the Policy even if *You* do not satisfy the *Actively at Work* requirement as stated in the *When does insurance become effective?* provision and *You* would otherwise be eligible to become insured under the Policy, *We* will provide limited coverage under this Plan. Coverage under this provision will begin on the Policy effective date and will continue until the earliest of:

1. The end of the month following the date *You* become *Actively at Work*;
2. The end of any period of continuance or extension provided under the *Prior Policy*; or
3. The date coverage would otherwise end, according to the provisions of the Policy.

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

#### ***Effect on Benefits***

If *You* do not satisfy the *Actively at Work* requirement, *You* may still be eligible for benefits under the Policy as follows:

The benefits payable under the Policy will be the benefits which would have been payable under the terms of the *Prior Policy* if it had remained in force; and the benefits payable under the *Policy* will be reduced by any benefits payable under the *Prior Policy* for the same *Disability* for which the prior carrier is liable.

The ***Prior Policy*** is the group disability insurance policy issued to the Policyholder by Harleysville Life Insurance Company whose coverage terminated immediately prior to the Policy Effective Date.

***Effect on Pre-existing Conditions***

If *You* have a *Disability* due to a *Pre-Existing Condition* after the *Prior Policy* has been replaced by this Plan, Benefits may be payable if:

1. *You* were insured under the *Prior Policy* at the time the Policyholder changed coverage from the *Prior Policy* to the *Policy*; and
2. *You* have been continuously insured under this Plan from the effective date of this Plan until the date *Your Disability* began.

In order for benefits to be paid, *You* must satisfy the *Pre-Existing Condition* exclusion under:

1. this Plan; or
2. the *Prior Policy*, if benefits would have been paid had the *Prior Policy* remained in force.

If *You* satisfy the *Pre-Existing Condition* exclusion of this Plan, *We* will determine *Your* payments according to this Plan's provision.

If *You* do not satisfy the *Pre-Existing Condition* exclusion of this Plan, but *You* do satisfy the *Pre-Existing Condition* provision under the *Prior Policy*:

1. *Your Monthly Benefit* will be the lesser of:
  - a. The *Monthly Benefit* that would have been payable under the terms of the *Prior Policy* if it had remained in force; or
  - b. The *Monthly Benefit* under this Plan.
2. Benefits will end on the earlier of:
  - a. The date benefits end under the *Policy*, as described under the Maximum Period Payable; or
  - b. The date benefits would have ended under the *Prior Policy* if it had remained in force.

If *You* do not satisfy the *Pre-Existing Condition* exclusion under either this Plan or the *Prior Policy*, *We* will not make any payments.

*We* will require proof that *You* were insured under the *Prior Policy*.

00010

## LONG TERM DISABILITY BENEFITS

### ***How do We define Total Disability?***

***Total Disability*** or ***Totally Disabled*** means that during the first 36 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 36 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 36 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 36 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 80% 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 60%
2. The maximum *Gross LTD Monthly Benefit* is \$5,000.00.
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 1/30<sup>th</sup> 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*;

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 for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
- Benefits are not payable if *Your Disability Earnings* exceed 80% of *Your* pre-disability *Indexed Monthly Earnings*.

- Benefits are not payable during the first 36 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 36 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

## 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 6 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 25.

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-VA

## 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 24 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 \$2,000 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-VA

### **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.

00050-VA

## 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*, his beneficiary or personal representative.

### ***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-VA

## 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 3% 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*.

00067

***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 36 consecutive months of *monthly payments*, the greatest extent of work *You* are able to do in *Your Regular Occupation*; and
2. Beyond 36 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:

- 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*.

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 whether or not the *Sickness* was diagnosed at all or was misdiagnosed within 3 months prior to *Your* effective date; and
2. begins in the first 12 months after *Your* effective date.

00081-VA

**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.

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.

00091-VA

**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 Fort Dearborn 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

**NOTICE OF  
PROTECTION PROVIDED BY  
VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary of the Virginia Life, Accident and Sickness Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created by Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,00 in cash surrender or withdrawal values
  
- Health Insurance
  - \$500,000 in hospital, medical and surgical insurance benefits
  - \$300,000 in disability income insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of health insurance benefits
  
- Annuities
  - \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at [www.valifega.org](http://www.valifega.org) or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS  
INSURANCE GUARANTY ASSOCIATION  
c/o APM Management Services, Inc.  
8001 Franklin Farms Drive, Suite 235  
Henrico, VA 23229  
804-82-2240

STATE CORPORATION COMMISSION  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
804-371-9741  
Toll Free Virginia Only: 1-800-552-7945  
<http://www.scc.virginia.gov/division/boi/index.htm>

Insurance companies and their agents are not allowed by Virginia law to use the existence of the Association or its coverages to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

**FORT DEARBORN LIFE INSURANCE COMPANY**

Chicago, Illinois  
**Administrative Office:**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of the insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Fort Dearborn Life Insurance Company

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Commonwealth of Virginia  
State Corporation Commission  
Bureau of Insurance  
Consumer Complaints/Inquiries  
P.O. Box 1157  
Richmond, VA 23218  
(877) 310-6560 (national)  
(804) 371-9691 (local)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.



Administrative Office:  
1020 31<sup>st</sup> Street • Downers Grove, Illinois 60515-5591

Products and services marketed under the Dearborn National<sup>TM</sup> brand and the star logo are underwritten and/or provided by Fort Dearborn 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, Puerto Rico and Guam.



# Experience Reports Package

Group Name

**MONTGOMERY COUNTY VIRGINIA**

Group Number

**FAE10189**

Experience Start Date

**April 1, 2011**

Experience End Date

**December 31, 2015**

Report Date

**January 11, 2016**



Disability Experience Summary

**MONTGOMERY COUNTY VIRGINIA**

Group Number: FAE10189

Report Date: January 11, 2016

**Long Term Disability Summary**

Period	Premium	Paid Claims	Average Volume	Average Lives	Paid Loss Ratio
4/1/2011 - 3/31/2012	44,701.46	1,380.30	1,240,614	370	3%
4/1/2012 - 3/31/2013	46,786.84	30,719.02	1,299,594	359	66%
4/1/2013 - 3/31/2014	49,915.87	8,594.24	1,386,464	366	17%
4/1/2014 - 3/31/2015	54,711.62	16,815.57	1,381,545	360	31%
4/1/2015 - 12/31/2015	35,355.47	15,781.41	1,339,096	338	45%
<b>Total</b>	<b>231,471.26</b>	<b>73,290.54</b>	<b>1,329,463</b>	<b>359</b>	<b>32%</b>



## Long Term Disability Experience Detail MONTGOMERY COUNTY VIRGINIA

Group Number: FAE10189

Report Date: January 11, 2016

Month/Year	Premium	Paid Claims	Volume	Lives	Paid Loss Ratio
04/2011	3,630.91	0.00	1,197,620	349	0%
05/2011	3,646.45	0.00	1,215,484	354	0%
06/2011	3,660.42	0.00	1,220,059	355	0%
07/2011	3,662.37	0.00	1,220,709	535	0%
08/2011	3,785.50	0.00	1,261,730	355	0%
09/2011	3,761.46	0.00	1,253,799	355	0%
10/2011	3,773.20	0.00	1,257,710	358	0%
11/2011	3,785.26	460.10	1,261,728	359	12%
12/2011	3,791.67	230.05	1,263,864	359	6%
01/2012	3,776.32	230.05	1,258,747	357	6%
02/2012	3,727.82	230.05	1,242,583	354	6%
03/2012	3,700.08	230.05	1,233,333	354	6%
<b>Period Totals</b>	<b>44,701.46</b>	<b>1,380.30</b>	<b>1,240,614</b>	<b>370</b>	<b>3%</b>
04/2012	3,709.23	230.05	1,236,380	352	6%
05/2012	3,709.28	3,045.32	1,236,389	357	82%
06/2012	3,713.74	2,878.20	1,237,866	354	78%
07/2012	3,738.92	17,243.04	1,246,257	357	461%
08/2012	3,896.12	1,217.72	1,298,639	354	31%
09/2012	3,938.84	1,755.00	1,312,869	358	45%
10/2012	3,982.81	3,517.38	1,327,653	363	88%
11/2012	3,991.30	4,481.36	1,330,379	360	112%
12/2012	4,011.84	4,481.36	1,337,237	363	112%
01/2013	4,007.48	3,841.84	1,335,798	361	96%
02/2013	4,040.28	2,378.84	1,346,711	361	59%
03/2013	4,047.00	-14,351.09	1,348,949	365	-355%
<b>Period Totals</b>	<b>46,786.84</b>	<b>30,719.02</b>	<b>1,299,594</b>	<b>359</b>	<b>66%</b>
04/2013	4,057.33	709.46	1,352,443	365	17%
05/2013	4,065.19	709.46	1,355,000	364	17%
06/2013	4,054.39	709.46	1,351,685	363	17%
07/2013	4,080.08	709.46	1,359,766	366	17%
08/2013	4,200.42	709.46	1,399,998	365	17%
09/2013	4,162.52	709.46	1,387,506	363	17%
10/2013	4,165.83	709.46	1,388,584	362	17%
11/2013	4,219.23	709.46	1,406,410	368	17%
12/2013	4,226.33	709.46	1,408,728	369	17%
01/2014	4,219.64	583.96	1,406,502	369	14%
02/2014	4,243.02	801.30	1,414,242	371	19%
03/2014	4,221.89	823.84	1,406,709	369	20%
<b>Period Totals</b>	<b>49,915.87</b>	<b>8,594.24</b>	<b>1,386,464</b>	<b>366</b>	<b>17%</b>
04/2014	4,646.78	823.84	1,408,116	372	18%
05/2014	4,690.03	823.84	1,421,221	377	18%
06/2014	4,652.71	823.84	1,409,759	375	18%
07/2014	4,621.83	823.84	1,400,434	374	18%
08/2014	4,540.81	823.84	1,376,002	367	18%
09/2014	4,516.87	823.84	1,368,748	352	18%
10/2014	4,626.24	823.84	1,401,785	364	18%
11/2014	4,461.16	823.84	1,351,928	362	18%
12/2014	4,618.96	2,778.28	1,399,571	347	60%
01/2015	4,481.49	2,778.28	1,357,926	349	62%
02/2015	4,425.19	2,374.52	1,340,862	343	54%
03/2015	4,429.55	2,293.77	1,342,189	342	52%
<b>Period Totals</b>	<b>54,711.62</b>	<b>16,815.57</b>	<b>1,381,545</b>	<b>360</b>	<b>31%</b>
04/2015	4,412.92	2,293.77	1,337,157	341	52%
05/2015	4,423.41	2,374.52	1,340,340	342	54%
06/2015	4,395.18	2,374.52	1,331,778	340	54%
07/2015	4,367.29	2,374.52	1,323,331	338	54%
08/2015	4,424.39	2,374.52	1,340,616	335	54%
09/2015	4,414.91	2,374.52	1,337,852	336	54%
10/2015	4,451.09	807.52	1,348,814	337	18%
11/2015	4,466.28	807.52	1,352,883	338	18%
12/2015	0.00	0.00	0	0	0%
<b>Period Totals</b>	<b>35,355.47</b>	<b>15,781.41</b>	<b>1,339,096</b>	<b>338</b>	<b>45%</b>
<b>Grand Totals</b>	<b>231,471.26</b>	<b>73,290.54</b>	<b>1,329,463</b>	<b>359</b>	<b>32%</b>