

UNITED HEALTHCARE INSURANCE COMPANY

LIFE INSURANCE

**ACCIDENTAL DEATH, DISMEMBERMENT
OR LOSS OF USE INSURANCE**

**CERTIFICATE OF COVERAGE
FOR**

ISLAMIC SOCIETY SALAM SC

GROUP NUMBER: G/GA363182NM

Offered and Underwritten by
United HealthCare Insurance Company





Table of Contents

SCHEDULE OF BENEFITS	2
GENERAL DEFINITIONS	3
CERTIFICATE GENERAL PROVISIONS	5
COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS	7
LIFE INSURANCE BENEFIT FOR COVERED PERSON	9
WAIVER OF PREMIUM - TOTAL DISABILITY FOR COVERED PERSON	11
ACCELERATED DEATH BENEFIT FOR COVERED PERSON	13
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON	14

United HealthCare Insurance Company
450 Columbus Boulevard
Hartford, Connecticut
(Home Office)

Policyholder: ISLAMIC SOCIETY SALAM SC

Effective Date of Policyholder: January 1, 2011

Policy Number: G/GA363182NM

Covered Person: As on file with the Administrator

Certificate Number: As on file with the Administrator

Certificate Effective Date: As on file with the Administrator

Beneficiary: As on file with the Administrator

We, United HealthCare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person and any Dependents, if applicable, eligible for insurance.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 866-293-1794.

It is signed at the Home Office of United HealthCare Insurance Company as of the Effective Date shown above.



Secretary



President

**Group Life, Accidental Death and
Dismemberment Insurance Policy
Non-Participating**

**Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343**

SCHEDULE OF BENEFITS

Class of Employees

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All full-time Employees working at least 30 hours per week.

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date.
2. The first day of the month on or next following the date after the Employee completes 1 month of service with the Employer.

Covered Person Insurance:

Annual Earnings Definition: The Annual Earnings received from the Covered Person's employer. Annual Earnings include commissions for the year ending prior to the Policy Anniversary period. It does not include bonuses, overtime pay and other extra compensation. Annual Earnings will be rounded to the next higher thousand.

Life Insurance Benefit:

Classification	Benefit Amount
Class Description	
All full-time Employees	\$ 50,000

Evidence of Insurability Requirements for the Employee Life Insurance Benefit

Employee Life Insurance Benefit amounts in excess of \$100,000 are subject to evidence of insurability. However, the Employee may not apply for amounts of insurance which exceed the Employee's eligible Life Insurance Benefit Amount that is stated above.

Reduction of Life Insurance Benefits at a Certain Age

Life Insurance Benefit will reduce to 65% at age 65, 50% at age 70.

Accelerated Death Benefit: Up to 50% of the Life Insurance in force to a maximum \$50,000. Employee must have at least \$10,000 in Life Insurance in-force to qualify for this benefit.

Accidental Death and Dismemberment Benefit:

The Accidental Death and Dismemberment Insurance Benefit is the same as the Life Insurance Benefit, however, the Accidental Death and Dismemberment Insurance Benefit will terminate at retirement.

Accidental Death and Dismemberment Insurance Benefits are issued on an occupational (24 hour) basis.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave.)

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Dependent: Includes

1. a legal Spouse; and
2. any unmarried Child.

A Child is:

1. less than 19 years of age; or
2. an Eligible Student;
 - a. who is not married;
 - b. who is not in the armed forces of any country;
 - c. who is not insured under the Policy as a Covered Person;
 - d. who is less than 27 years of age;
 - e. who attends an accredited post-secondary school (other than a correspondence school) on a full-time basis as defined by the post-secondary school; and
 - f. is enrolled in the next scheduled term.
or
3. unmarried and physically or mentally Disabled.

The term "Child" includes a natural child, legally adopted child, stepchild, foster child, or any child who lives with the Covered Person in a regular parent-child relationship, provided the Covered Person claims such Child as a Dependent on the Covered Person's most recent federal income tax return.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of the Policyholder will be considered an Employee unless he meets the above conditions.

GENERAL DEFINITIONS

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: United HealthCare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Discretionary Authority: When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision applies, however, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 31 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Payment of Premium Within ten (10) days prior written notice, insurance will terminate as of the end of the Grace Period. The Company will subtract the premium due for the Grace Period from any benefits payable. for a period before it is due will not guarantee that the insurance will remain in effect for that period.

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 12-month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

CERTIFICATE GENERAL PROVISIONS

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Termination of the Group Policy: The Group Policy will terminate on the date the Policyholder terminates the Group Policy. The Policyholder must give 31 days advance written notice to Us.

The Company may terminate the Group Policy with advance written notice delivered at least ten days prior to the termination date for the following conditions:

1. on the Premium Due Date of any premium which remains unpaid at the end of the Grace Period.
2. at Our election on the Premium Due Date following the date the number of Covered Persons insured under the Group Policy is less than 2.
3. the date on which the Policyholder fails to comply with or intentionally makes material misrepresentation relating to the Group Policy.

Termination may take effect on an earlier date when both the Policyholder and We agree.

We reserve the right to terminate insurance under the Group Policy on the date that the number of Covered Persons insured under the Policyholder decreases to less than:

1. 75% of all eligible employees of the Policyholder, if the Policyholder contributes partially towards the cost of insurance;
2. 100% of all eligible employees of the Policyholder, if the Policyholder contributes in whole towards the cost of insurance; or
3. 2 Covered Persons.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
 - a. the date the Employee is eligible for insurance, regardless of when he applies; or
 - b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Effective Date of Change in Amount of Insurance: If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

1. the first day of the month on or next following the date of the increase;
2. the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the date of the increase effective date;
3. the date of the increase, if the first day of the month is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day;
4. the first day of the month on or next following the date of the increase if the Covered Person is on an approved layoff or leave of absence, for reasons other than a Sickness or Injury.

If evidence of insurability is required, the increase will take effect on the later of the dates indicated above or the date We approve his application.

A decrease in the amount of the Covered Person's insurance will take effect on the date of the decrease.

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his employer.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the last day of the month in which he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the last day of the month in which he ceases to be Actively at Work, unless
 - a. Active work ceases during an approved layoff, medical leave or non-medical leave of absence, the Life Insurance Benefit and the Accidental Death and Dismemberment Benefit will continue for up to 3 months from the date he stopped active work.
 - b. Active work ceases as a result of a disability due to a sickness or accidental injury and:
 - i. that disability began before age 60: and
 - ii. the Covered Person remains continuously disabled.

The Life Insurance Benefit and the Accidental Death and Dismemberment Benefit may be continued for up to 12 months from the date he stopped active work.
5. the date he is no longer Actively at Work due to a labor dispute, including but limited to strike, work slow down or lock out.

LIFE INSURANCE BENEFIT FOR COVERED PERSON

Death Benefits: We will pay the Covered Person's beneficiary the amount of insurance in force on the date of death when We receive satisfactory proof of a Covered Person's death. The benefit will be paid in accordance with the beneficiary section.

Assignment: Life insurance as provided by the Policy may be assigned as an absolute assignment only. In making an assignment, the Covered Person must transfer all his present and future ownership rights to the person to whom he assigned the insurance. This includes the right to change the beneficiary and to convert the insurance. The Covered Person may not make a collateral or partial assignment of his insurance.

Beneficiary: The Covered Person's beneficiary will be the person(s) he names in writing to receive any amount of insurance payable due to his death.

The Covered Person may name or change a beneficiary by giving Us written notice at Our Home Office on a form acceptable to Us. When We receive the notice, it will be effective on the date made, subject to any payment We may have made before We receive it.

If the Covered Person names more than one beneficiary, those who survive will share equally unless the Covered Person specifies otherwise. If there is no named beneficiary living at the Covered Person's death, We will pay any amount due to the estate or, at Our option, to his:

1. legal spouse;
2. natural or legally adopted children in equal shares; or
3. estate.

Notice of Claim: Written notice of a claim for death must be given to Us at Our Home Office by the Covered Person's beneficiary. Written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the form is not received from Us within 15 days of a request, written proof of claim should be sent to Us without waiting for the form. Written proof must show the cause of death. Also, a certified copy of the death certificate must be given to Us.

Proof of Claim: Written proof of claim must be filed with Us.

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than six years after the date of loss.

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Settlement Options: Instead of a single payment, the Covered Person may choose to have all or part of the insurance paid under one of the settlement options We have available. We will give the Covered Person full information about the options upon request.

Conversion Privilege: The Covered Person may convert:

1. all or part of his Life Insurance to an individual policy of life insurance, other than term, if his insurance terminated because he ceases to be a member of a class eligible for insurance;
2. the amount of insurance to an individual policy of life insurance, other than term, that is lost due to a reduction of insurance because of age;

LIFE INSURANCE BENEFIT FOR COVERED PERSON

3. a limited amount of insurance to an individual policy of life insurance, other than term, if he has been continuously insured under the Policy (or the policy it replaced) for five years and the insurance terminated due to termination or amendment of the Policy. The amount the Covered Person may convert in this case is the smaller of the following:
 - a. the amount of Life Insurance which terminates, less the amount he became eligible for under any Policy within 31 days after this insurance terminated; or
 - b. \$10,000.

The Covered Person may convert to any policy, other than term, We are issuing for the purpose of conversions. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. Written application and the first premium payment for the conversion policy must be received in Our Home Office within 31 days after his insurance terminates. The premium will be based on the amount and the form of the conversion policy, and on his class of risk and age on the date the conversion takes effect.

If the Covered Person dies within the 31 days allowed for making application to convert, We will pay the amount he was entitled to convert. We will do this whether or not application was made.

A conversion policy is in lieu of benefits under this section of the Policy. However, if the Covered Person is qualified for the Waiver of Premium-Total Disability provision, the converted policy will be cancelled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the later of:

1. its date of issue; or
2. 31 days after the date this insurance terminates.

The insurance under the Policy may be reinstated within one year after termination of employment, if the Covered Person has converted and he:

1. gives Us proof that he was Totally Disabled when his insurance terminated and that his insurance would have continued in force under the Waiver of Premium-Totally Disabled provision if he had not converted; and
2. surrenders the conversion policy to Us without claim in return for premiums paid less any unpaid policy loans.

Employees rehired after converting insurance must either lapse that insurance or provide evidence of insurability to keep that individual policy.

WAIVER OF PREMIUM - TOTAL DISABILITY FOR COVERED PERSON

We will continue the Covered Person's Life Insurance in force without premium payment while he remains Totally Disabled if he:

1. becomes Totally Disabled before age 60;
2. remains Totally Disabled continuously for at least nine consecutive months;
3. gives Us proof of Total Disability, as required.

We will waive the Covered Person's premium payment on a monthly basis, beginning the first day of the month after the month he became Totally Disabled. We will refund any premium paid for the Life Insurance after that day. We will not refund premiums for any period more than 12 months before the date proof of disability was furnished. This Waiver of Premium will continue to be effective even if the Policy terminates after the Covered Person becomes Totally Disabled.

Amount of Life Insurance Under the Total Disability Benefit: The amount of insurance continued would be the amount in force on the date the Covered Person became Totally Disabled. This amount will be reduced or terminated, based on the Schedule of Benefits in effect on the date of Total Disability. This amount will not be increased while the Covered Person remains Totally Disabled. All other Benefits will be terminated.

Death While Totally Disabled: If the Covered Person dies while his Life Insurance is being continued under Waiver of Premium, We will pay the amount of insurance if We receive proof:

1. of the Covered Person's death; and
2. that Total Disability was continuous from the date it began to the date of death.

Proof of Total Disability: We will provide forms which the Covered Person must use when giving Us proof of Total Disability. The Covered Person must give Us proof no later than 12 months after the date he became Totally Disabled. We may at any time require proof that Total Disability continues. The Covered Person must give Us proof within 60 days after Our request. After the Covered Person has been Totally Disabled for more than two years from the date of Total Disability, We will not request proof any more than once a year. We may require the Covered Person to be examined, at Our expense, by a Physician of Our choice.

Total Disability or Totally Disabled: For purposes of this section, the Covered Person will be considered Totally Disabled if he is unable to perform each and every duty of his occupation at his usual place of employment and he is unable to do the material and substantial duties of any job suited to his education, training or experience.

We may require the Covered Person to be examined by a Physician, other medical practitioner or vocational expert of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so.

Termination of the Total Disability Benefit: The Covered Person will no longer be eligible for the Total Disability Benefit and his Life Insurance will terminate on the earlier of the following dates:

1. the date the Covered Person ceases to be Totally Disabled. However, if he is still eligible for Life Insurance when he returns to Active Work, his Life Insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of Life Insurance he may then be eligible for will take effect as described in the Effective Date of insurance provision; or
2. the last day of the 60-day period following Our request for proof of Total Disability, if he does not give Us proof or refuses to take a medical exam;
3. the date the Covered Person reaches age 65;
4. the date premium has been waived for 12 months and the Covered Person is considered to reside outside the United States. The Covered Person is considered to reside outside the United States when he has been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

WAIVER OF PREMIUM - TOTAL DISABILITY FOR COVERED PERSON

If the Covered Person's Total Disability ends and he does not return to Active Work, then the Covered Person may exercise the Conversion Privilege.

ACCELERATED DEATH BENEFIT FOR COVERED PERSON

The Accelerated Death Benefit payment may be taxable to the Covered Person. The Covered Person should seek assistance from his personal tax advisor regarding taxes the Covered Person may have to pay as the result of claiming Accelerated Death Benefits.

If while insured under the Policy, the Covered Person becomes terminally ill (called the "qualifying event") with a life expectancy of less than 12 months and the Covered Person has met all of the conditions set forth below, We will pay the Covered Person the amount of insurance shown in the Schedule of Benefits.

The Covered Person may elect to receive an Accelerated Death Benefit amount that is stated on the Schedule of Benefits. However, an Accelerated Death Benefit payment against the Covered Person's Life Insurance Benefit can only be made once in the Covered Person's lifetime.

The Life Insurance Benefit amount will be reduced by the amount paid under this provision.

The Covered Person must submit written medical evidence signed by the treating Physician and acceptable to Us that he is:

1. under a Physician's care for that condition, and
2. has a life expectancy of less than 12 months.

The Accelerated Death Benefit amount will be paid to the Covered Person after the Covered Person meets all of the conditions listed above.

We reserve the right to ask for a medical exam in connection with a claim.

The Covered Person must continue to pay any applicable premium for the amount of Life Insurance Benefits remaining after the reduction.

Upon the Covered Person's death, the amount of Life Insurance Benefits paid to the Covered Person's beneficiary will be reduced by the amount already paid under this provision.

Limitations: Accelerated Death Benefits will not be payable if:

1. the Covered Person has assigned his Life Insurance Benefits; or
2. We have been notified that all or a portion of the Life Insurance Benefits are to be paid to the Covered Person's former spouse as part of a divorce agreement; or
3. the Covered Person is required by law to accelerate benefits in order to meet the claims of creditor(s); or
4. the Covered Person is required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement.

The Accelerated Death Benefit is not available to Retired Covered Persons.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON

If the Covered Person suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section;
2. the Sickness began while the Covered Person was insured under the Policy;
3. loss occurred within 90 days after the Injury; and
4. loss was due to Injury independent of all other causes.

Amount of Insurance: The amount of insurance shown in the Schedule of Benefits will be paid according to the following table:

Loss of life	100%
Loss of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Loss of one hand	50%
Loss of one foot	50%
Loss of sight of one eye	50%
Loss of speech	25%
Loss of hearing	25%

Loss of sight means total and irrecoverable loss of sight. Loss of hands or feet means severance at or above the wrist or ankle. Loss of thumb and index finger means the actual, complete and permanent severance through or above the metacarpophalangeal joints. Loss of speech means the total and irrecoverable loss of speech. Loss of hearing means total and irrecoverable loss of hearing. Quadriplegia means total and permanent Paralysis of both upper and lower limbs. Paraplegia means total and permanent Paralysis of both lower limbs. Uniplegia means the total and permanent Paralysis of one limb. Triplegia means the total and permanent Paralysis of three limbs. Hemiplegia means total and permanent Paralysis of upper and lower limbs on one side of the body. Paralysis means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb.

In paying this benefit, We will consider only losses sustained while insured under this section of the Policy. We will pay no more than the full amount shown in the Schedule of Benefits for losses resulting from any one Injury.

Seat Belt Benefit for Covered Person: We will pay a Seat Belt benefit in the amount of an additional amount equal to 10% of the full amount for the loss of the Covered Person's life that results from injuries sustained while driving or riding in a private Passenger Car if such Covered Person's Seat Belt was properly fastened. However, the amount payable will not exceed \$10,000. A benefit is not payable under this provision, if:

1. the Covered Person is either a driver or passenger, and the driver was legally intoxicated or under the influence of drugs at the time of the accident; or
2. the driver of the private Passenger Car does not hold a current and valid driver's license at the time of the accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON

Passenger Car means, for the purposes of this Accidental Death and Dismemberment Benefit, any validly registered four-wheel private Passenger Car. Seat Belt means any restraint device which meets published federal safety standards, has been installed by the car manufacturer or reinstalled according to the manufacturer's specifications and has not been altered after such installation. The investigating officer must certify the correct position of the Seat Belt. A copy of the police report must be submitted with the claim.

Limitations: We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or medical or surgical Treatment of these;
2. suicide or intentionally self-inflicted Injury, while sane or insane;
3. participation in a riot or insurrection, or commission of an assault or felony;
4. war or any act of war, declared or undeclared;
5. use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;
6. driving while intoxicated, as defined by the applicable state law where the loss occurred;
7. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation or bungee jumping;
8. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an occupational (24 hour) basis as shown in the Schedule of Benefits;
9. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

Notice of Claim: Written notice of a claim for death or Injury must be given to Us at Our Home Office by the Covered Person or his beneficiary within 30 days of the date of death or the date the Injury occurred. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature, and extent of the loss involved.

Proof of Claim: Written proof of claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than six years after the date of loss.

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Assignment: Accidental Death and Dismemberment insurance provided by the Policy cannot be assigned.

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS DENIAL FOR LIFE INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 90 days following the receipt of the claim or within 90 days following the expiration of the initial 90 day period, in a case where there are special circumstances requiring extension of time for processing the claim. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 90 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial; 2) reference to the provision(s) of the Plan on which the denial is based; 3) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; and 4) an explanation of the claim review procedure. If written notice of the denial is not furnished to the claimant within 90

days (or if an extension was required, 180 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR LIFE INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 60 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 60 day period, but no later than 120 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 60 day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the final written decision is not furnished to the complainant within 60 days (or if an extension was required, 120 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.

