Group Short Term Disability Insurance

Employee Benefit Booklet

CITY OF WOODSTOCK

F013530-0001

Class 1-01

04/19/2013

FORT DEARBORN LIFE
Insurance Company®

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

(A stock life insurance company, herein called the "We" "Us" or "Our")

Having issued Group Policy No. F013530-0001

(herein called the Policy)

to

CITY OF WOODSTOCK

(herein called the Policyholder)

Group Insurance Certificate

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 Short Term Disability Insurance Certificate
Non-Participating

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SCHEDULE OF BENEFITS

***Policyholder*:**	CITY OF WOODSTOCK
Policy Number:	F013530-0001
Effective Date:	September 1, 2011 (Amended: 03/01/2013)
Eligibility: **Class 01**	ALL ACTIVE FULL TIME EMPLOYEES EXCLUDING ELECTED AND APPOINTED OFFICIALS working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a required number of hours per week for the *Policyholder*. Part-time, seasonal and temporary employees of the *Policyholder* are not eligible. The required weekly number of hours worked are as follows: All other employees excluding elected and appointed officials: 40 hours per week Police officers: 43 hours per week Firefighters: 53 hours per week
Eligibility Waiting Period:	**<u>Current Employees</u>** If *You* are in a class eligible for insurance on or before the Policy Effective Date: 0 Days of continuous, full-time active work **<u>New Employees</u>** If *You* enter a class eligible for insurance after the Policy Effective Date: 0 Days of continuous, full-time active work
Short Term Disability STD Benefit Percentage	60% of *Your* Weekly Earnings, not to exceed $2,000.00
Maximum STD Weekly Benefit	$2,000.00
Minimum STD Weekly Benefit	$25.00
Elimination Period	14 Days - Injury 14 Days - Sickness
Benefits are Payable on	Day 15 of *Injury* Day 15 of *Sickness;*
Maximum Period Payable	11 Weeks following the Elimination Period or until benefits become payable under the Long Term Disability plan, whichever occurs first
Benefits are Payable for	Non-occupational disabilities only
Policyholder Contribution	100% of Premium

OTHER FEATURES

- Work Incentive Benefit
- Recurrent Disability
- Worksite Modification
- Survivor Benefit
- FMLA Coverage Extension

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 DATE PROVISIONS

Who is eligible for this insurance?

ALL ACTIVE FULL TIME EMPLOYEES EXCLUDING ELECTED AND APPOINTED OFFICIALS working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a required number of hours per week for the *Policyholder*. Part-time, seasonal and temporary employees of the *Policyholder* are not eligible.

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 later of the Policy effective date or the first of the month that falls on or next follows 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.

Noncontributory means the *Policyholder* pays 100% of the premium for this insurance.
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You must be *Actively at Work* for coverage under the Policy to become effective.

When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after the date *You* are eligible for insurance; or
2. *You* voluntarily canceled *Your* insurance and are reapplying; or
3. *You* apply for coverage amounts in excess of the Guarantee Issue Benefit Limit as shown in the Schedule of Benefits.

Evidence of ***Insurability*** means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. *Evidence of Insurability* will be provided at *Our* expense.

Evidence of Insurability Form means a form provided or approved by Us on which you provide a statement of your medical history.

You may obtain an *Evidence of Insurability Form* from *the Policyholder*.
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If You are not Actively at Work, when does coverage become effective?

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an injury, illness or layoff,

Your effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work.* However, *You* will be considered *Actively at Work* on any day that is not Your regularly scheduled work day (including but not limited to a weekend, vacation or holiday if *You* were *Actively at Work* on the immediately preceding scheduled work day and You were:

1. not *Hospital Confined*; or
2. disabled due to an *Injury or Sickness*.

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Changes to Your coverage

A change in *Your* coverage may occur if:

1. There is a Policy change; or
2. *You* enter another class and become eligible for a change in benefits

Your insurance will take effect on the day of the change, provided You are Actively Working on the day.

If You are not Actively Working on the day of the change, the following conditions will apply:

1. If the change involves an increase in the amount of insurance, the change will not take effect until the day You return to Active Work.
2. If the change involves a decrease in the amount of insurance, the change will take effect on the day of the change.

In no event will any change take effect during a period of Disability.

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Who pays for Your coverage?

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

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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 paid 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* whose coverage terminated immediately prior to the Policy Effective Date.

We will require proof that *You* were insured under the *Prior Policy*.
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Eligibility after You Terminate Employment

If *Your* coverage ends due to termination of employment, *You* must meet all the requirements of a new *Employee* if *You* are rehired at a later date.

Exception: If *Your* coverage ends due to termination of employment and you return to *Active Work* in an eligible class within 6 months, we will not:

1. apply a new *Eligibility Waiting Period*;
2. require *Evidence of Insurability*.

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SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or ***Disabled*** means that *You* satisfy the definition of either *Total Disability* or *Partial Disability* and *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*.

Unless periods of *Disability* are separated by *Your* return to *Active Work* for at least 14 consecutive days, successive periods of *Disability* resulting from injuries received in any one *Accident* or from any one *Sickness* or related *Sicknesses* will be considered one period of *Disability*.
00014

How do We define Total Disability?

Total Disability or ***Totally Disabled*** means that due to *Sickness* or *Injury You* are continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*, and *Your Disability Earnings*, if any, are less than 20% of *Your* pre-disability *Weekly Earnings*.

00015

How do We define Partial Disability?

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

1. During the *Elimination Period You* are able to perform some but not all of the *Material & Substantial Duties* of *Your Regular Occupation*; and
2. After the *Elimination Period*, due to *Injury* or *Sickness, You* are able to perform some but not 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 99% of *Your* pre-disability *Weekly Earnings*.

You will no longer be considered Partially Disabled when *You* are able to increase *Your* current earnings by increasing the number of hours *You* work or the number of duties *You* perform in *Your Regular Occupation* but *You* do not do so.
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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*.

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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 14 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 14 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period.*
00020

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*.

00021

What Disability Benefit are You eligible to receive?

If *You* are *Disabled* and receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor, You* are eligible to receive one of the following at any given time:

1. an *STD Weekly Benefit*; or
2. a Work Incentive Benefit.

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.
00022

What is *Your STD Weekly Benefit* and how is it calculated?

Your STD Weekly Benefit will be based on *Your Weekly Earnings* as reported to *Us* by *Your* Employer and for which premium has been paid.

An *STD Weekly Benefit* will be payable after the end of the *Elimination Period* if *You* are *Disabled*.

We will calculate *Your Gross STD Weekly Benefit* amount as follows:

1. Multiply *Your Weekly Earnings* by the STD Benefit Percentage, shown on the *Schedule of Benefits*.
2. The maximum *STD Weekly Benefit* as shown on the *Schedule of Benefits*.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross STD Weekly Benefit*.
4. Subtract the Deductible Sources of Income from *Your Gross STD Weekly Benefit*. The resulting figure is *Your Net STD Weekly Benefit*.

If a benefit is payable for less than one week, *STD Weekly Benefit* payments will be made at a daily rate of 1/7th the weekly benefit.
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If *You* are receiving any compensation from *Your* Employer, including, but not limited to:

1. *Salary Continuation*;
2. sick leave benefits; or
3. vacation pay,

We will not begin *STD Weekly Benefit* payments until such compensation payments cease.
00024

Can You work and still receive benefits?

While *Partially Disabled*, *You* may qualify for the Work Incentive Benefit.

00025

What is the Work Incentive Benefit and how is it calculated?

We will pay a Work Incentive Benefit if *You* are *Partially Disabled* and *Gainfully Employed* after the end of the *Elimination Period*, or after a period during which You received *STD Weekly Benefits.*

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 *STD Weekly Benefits*.

The Work Incentive Benefit will be calculated while *You* are *Gainfully Employed* as follows:

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

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

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

The payment of a Work Incentive Benefit, combined with *Your STD Weekly Benefit*, will not extend the *Maximum Period Payable*, as shown on the *Schedule of Benefits.*
00026

What are the Deductible Sources of Income?

The *Gross STD Weekly Benefit* under the Policy will be reduced by:

1. Disability benefits paid, payable or for which *You* are eligible under:
   a. any state compulsory disability benefit *Act* or *Law*.
   b. any group insurance plan provided by or through the *Policyholder*.
   c. any State Teachers Retirement System, Public Employees Retirement System or School Employees Retirement System.
   d. the Social Security *Act*, including any amounts for which *Your* dependents may qualify because of *Your Disability.*
   e. the Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act.
   f. the Canada Old Age Security Act.
   g. any Workers' Compensation or Occupational Disease *Act* or *Law*, or any other *Law* which provides compensation for an occupational *Injury* or *Sickness.*

      Denial of Workers' Compensation will not result in the payment of benefits under the Policy if *Your Disability* resulted from an occupational *Sickness* or *Injury*. Benefits are also not payable under the Policy if *You* are entitled to participate in Workers' Compensation and choose not to do so.
2. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;
3. Retirement and *Disability* benefits paid under a Retirement Plan provided by the *Policyholder* except for amounts attributable to *Your* contributions;
4. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;
5. Amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the net settlement.

Act or ***Law*** means the original enactment of the law or act and all amendments.

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 STD Weekly Benefit* as follows:

1. *We* will divide the amount paid by the number of weeks for which the settlement or advance was provided; or
2. If the number of weeks 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 weeks for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 26 weeks.

What other sources of income are not deductible?

We will not reduce *Your Gross STD Weekly Benefit* under the Policy 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 Employer;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

00028

What is the minimum Net STD Weekly Benefit payable under the Policy?

The *Net STD Weekly Benefit* payable for *Disability* will not be less than $25.00. The minimum *Net STD Weekly Benefit* does not apply if *You* are *Gainfully Employed.*

00029

What happens if Your Deductible Sources of Income increase?

The *Net STD Weekly 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.

00030

How long will You receive benefits under the Policy?

We will send *You* a payment for each week 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*.

00031

What happens if Your Disability recurs?

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Elimination Period if:

(a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability: and

(b) Your Recurrent Disability occurs within 90 days of the end of Your claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other group disability income policy or plan.

00032

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 to, directly or indirectly, by any one or more of the following:

1. loss of professional license, occupational license or certification.
2. commission of, participation in, or an attempt to commit an assault or felony;
3. Intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. *Cosmetic Surgery* except when required due to *Injury* or *Sickness*;
6. Occupational *Injury* or *Sickness;*
7. participation in a war, declared or undeclared, or any act of war.

Furthermore:

1. Benefits are not payable if *Your Disability Earnings* exceed 80% of *Your* pre-disability *Weekly Earnings*.
2. Benefits are not payable if *You* are able to return to work in *Your Regular Occupation* on a part-time basis but *You* do not.
3. 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.

00033

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 *You*:
    a. are no longer a member of a class eligible for this insurance,
    b. request termination of coverage under the Policy in writing,
    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 *Your* claim for a covered loss which began while the coverage was in force.
00034 GA

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.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a spouse, child or parent due to their serious illness; or
5. For *Your* own serious health condition.

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*.

If the *Policyholder*'s Human Resource policy does not provide for continuation of an Employee's Short Term Disability coverage during a family and medical leave of absence, the Employee's coverage will be reinstated when he or she returns to active employment.

We will not:

1. apply a new *Eligibility Waiting Period*;
2. apply a new *Pre-existing Condition* exclusion
3. require *Evidence of Insurability*.

00035

SUPPLEMENTAL BENEFITS

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 STD Weekly 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 the *Policyholder* have been provided to *Us*; and
3. *You* have returned to work and are an *Actively at Work* Employee.

For the purposes of this provision, *Last STD Weekly Benefit* means the weekly 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.*
00038

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 *You* had received *STD Weekly Benefits* for 3 or more consecutive weeks; and
2. While receiving an *STD Weekly Benefit.*

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

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

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

1. the children, in equal payments; 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.

For the purposes of this provision, ***Last STD Weekly Benefit*** means the weekly 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.
00039

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 10 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 10 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. Ho*we*ver, 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. Ho*we*ver, *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 Weekly 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.

00040 GA

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit at least as frequently as once every two weeks, as long as *You* continue to qualify for it. Any balance remaining unpaid upon the termination of the period of liability will be paid immediately after *We* receive due written proof. Valid claims not paid according to these terms will be increased by interest at the rate of 18% per annum until finally settled.

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

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

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 Weekly 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 *STD Weekly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *STD Weekly Benefits* payable under the Policy.
00041 GA

Subrogation – Right of Reimbursement

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

00042

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 bet*we*en the parties. Coverage under the Policy can be amended by mutual consent betw*e*en the *Policyholder* and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

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

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

Legal Actions

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

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

Clerical Error

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

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

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

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

Misstatement of Age

If *Your* age has been misstated, an equitable adjustment will be made in the premium.

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.

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.

00043 GA

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 to these definitions.

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.
00044

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 or Canada;
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); and

You were not *Hospital Confined* or disabled due to an *Injury* or S*ickness*.
00045

Act or ***Law*** means the original enactment of the law or act and all amendments.
00047

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.
00049

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*.
00050

Cosmetic Surgery means any procedure which is directed at improving a person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
00053

Date of Disability means the date We determine that You are *Disabled*.
00054

Disability Earnings means the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. 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 week to week, *We* may average *Your Disability Earnings* over the most recent three weeks 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 weeks exceeds 80% of *Your Weekly Earnings.*
00055

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.
00056

Domestic Partner means an adult of the same or opposite gender who has executed a *Domestic Partner* affidavit, or 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.
00057

Eligible Survivor means *Your* Spouse, if living, or if *Your Spouse* dies before the benefit is paid, then *Your* children who are under age 23.
00058

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*.
00059

Employee means an *Actively at Work* full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is *Actively at Work* for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.
00060

Evidence* of *Insurability means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. *Evidence of Insurability* will be provided at *Our* expense.
00061

Evidence of Insurability Form means a form provided or approved by Us on which you provide a statement of your medical history.
00062

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 means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
00064

Gross STD Weekly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You.*
00065

Hospital means either of the following:

1. A licensed hospital which
    a. maintains on the premises all facilities necessary for major surgical treatment,
    b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed physicians, and
    c. provides 24-hour service by registered graduate nurses.
2. A free-standing surgical facility which maintains on the premises all facilities necessary for major surgical treatment.

The term *Hospital* does not include an institution which is primarily a place for rest or convalescence, a place for the aged, a nursing home, a place for the treatment of alcohol or drug abuse or any facility primarily affording custodial, educational, or rehabilitative care.
00066

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*.
00067

Last STD Weekly Benefit, for the Worksite Modification Benefit, means the weekly 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.*
00068

Last STD Weekly Benefit, for the Survivor Benefit, means the weekly benefit paid to *You* immediately prior to *Your* death, but not including any reductions for *Deductible Sources of Income.*
00069

Male pronoun, whenever used, includes the female.
00070

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.

00071

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.
00072

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*.
00073

Net STD Weekly Benefit means the *Gross STD Weekly Benefit* less the Deductible Sources of Income.
00075

Noncontributory means *Your* Employer pays 100% of the premium for this insurance.
00076

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the *Policyholder* is a trust, the term Participating Employer shall be substituted for *Policyholder*.
00078

Prior Policy means the group disability insurance policy issued to the *Policyholder* whose coverage terminated immediately prior to the Policy Effective Date.
00080

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.
00081

Schedule of Benefits means the schedule which is a part of this certificate.
00082

Sickness means sickness or disease causing *Disability* which begins while *You* are covered under the Policy.
00083

Spouse means lawful spouse in the jurisdiction in which *You* reside. *Spouse* will include Y*our Domestic Partner.*
00084

STD means Short Term Disability.
00085

STD Weekly Benefit means the *STD Weekly Benefit* shown in the *Schedule of Benefits* which applies to *You*.
00086

Waiting Period as shown in the *Schedule of Benefits* 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*.
00087

Weekly Earnings means *Your* gross weekly income from Your Employer in effect just prior to Your Date of Disability. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account.

It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.
00088

We, Our and ***Us*** mean the Fort Dearborn Life Insurance Company, Chicago, Illinois.
00089

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.
00090

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