

**APPENDIX C**  
**GROUP LONG TERM DISABILITY PLAN**

**Section C1.01 Insurance Benefits.** Group long term disability benefits under this Group LTD Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract (“Hartford Life Group Contract”) between Hartford Life and Accident Insurance Company (“Hartford Life”) and the Employer (Group Policy No. 83124976). The provisions of that group contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Hartford Life. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. For example, in the event of Hartford Life’s insolvency, the Participant shall bear fully any and all risk of such insolvency. The rights and conditions with respect to the benefits payable under this Group LTD Plan shall be determined from the Hartford Life Group Contract.

**Section C1.02 Cost of Coverage.** The Participant's monthly premiums are determined pursuant to the Hartford Life Group Contract. Under that agreement, Hartford Life may change the premiums from time to time. The Employer shall increase each Eligible Employee’s pay period base salary by an amount equal to the then current monthly premium cost. Premiums shall then be paid by Participants on an after-tax basis.

**ATTACHMENT C-1**  
**FARM CREDIT FOUNDATIONS**  
**GROUP LTD PLAN**

**Hartford Life and Accident Insurance Company**

**Group Policy Number      83124976**

**Please place a copy of the underlying insurance policy behind this page.**

# **Group Long Term Disability Insurance**

**Designed for Employees of**

**Farm Credit Foundations  
Plan Sponsor Committee**







**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**Simsbury, Connecticut**  
(A stock insurance company)

**Having issued Group Policy No. 83124976**

**to**

**Farm Credit Foundations Plan Sponsor Committee**

**(herein called the Employer)**

**CERTIFICATE OF INSURANCE**

CERTIFIES that *You* are insured provided that *You* qualify under the ELIGIBILITY 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 EFFECTIVE DATE 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.

CDI-1AB

Signed for Hartford Life and Accident Insurance Company

**Richard G. Costello, Secretary**

**Thomas M. Marra, President**

**Group Long Term Disability Certificate**

**SBDI-C**

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

CDI-3AA

## **SCHEDULE OF BENEFITS**

**Effective as of: March 23, 2007**

**Employer:** Farm Credit Foundations Plan Sponsor Committee  
**Policy Number:** 83124976  
**Effective Date:** January 1, 2005

### **Class 1**

**Eligibility:** All full-time and part-time benefits eligible employees working in the United States of America who are Actively at Work for the Employer, and who ARE participating in a defined benefit retirement plan. Temporary employees are not eligible.

### **Class 2**

**Eligibility:** All full-time and part-time benefits eligible employees working in the United States of America who are Actively at Work for the Employer, and who are NOT participating in a defined benefit retirement plan. Temporary employees are not eligible.

A benefits eligible employee is one who regularly works a minimum of 20 hours or more per week for the Employer.

**Waiting Period:** No Waiting Period

**Elimination Period:** 180 Days  
Catastrophic Disability Benefit: 180 Days

**LTD Monthly Benefit:** 66 2/3% of *Monthly Earnings* to a maximum benefit of \$20,000 per month subject to reduction by deductible sources of income or *Disability Earnings*.

**Social Security Offset Method:** Family Social Security

**Employer Contribution:** 0% of premium  
Mandatory Participation by all eligible employees.  
Eligible employees retain the right to waive coverage.

**Maximum Period Payable:**

<b><u>AGE AT DISABILITY</u></b>	<b><u>Maximum Period Payable</u></b>
Age 61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*, whichever is longer
Age 63	36 months or to Retirement Age*, whichever is longer
Age 64	30 months or to Retirement Age*, whichever is longer
Age 65	24 months or to Retirement Age*, whichever is longer
Age 66	21 months or to Retirement Age*, whichever is longer
Age 67	18 months or to Retirement Age*, whichever is longer
Age 68	15 months or to Retirement Age*, whichever is longer
Age 69 or over	12 months

**\*SOCIAL SECURITY NORMAL RETIREMENT AGES**

Based on the 1983 Rider to the Social Security Act, the following are normal retirement ages by date of birth:

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

**Reinstatement:**

If, after termination of an employee's coverage because of termination of employment, the employee is rehired within 12 months after the date of termination and is eligible as stated in the Eligibility provision, the employee's coverage may be reinstated. The request for reinstatement and payment of premium must be made within 31 days after becoming eligible again.

Coverage will be reinstated and become effective on the date *Your* reinstatement is accepted by the Employer or *Us*, provided *You* are *Actively-at-Work*. If *You* are not *Actively-at-Work* on that date, the effective date of the reinstatement will be the date *You* return to *Active Work*.

Time periods for *Pre-existing Conditions* will be credited for the period between the employee's date of termination and the date of reinstatement as if there had been no break in coverage.

## ***OTHER FEATURES***

The following other features are included:

- Waiver of Premium
- Work Incentive Benefit
- Minimum Benefit
- Recurrent Disability
- FMLA Coverage Extension
- Conversion Privilege
- Survivor Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- Catastrophic Disability Benefit
  - Caregiver Respite Benefit
  - Caregiver Training Benefit
  - Emergency Alert System Benefit
- Presumptive Disability Benefit
- Continuity of Coverage

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

SOBC

## **ELIGIBILITY AND EFFECTIVE DATES**

### **Are You eligible for this insurance?**

#### **Class 1**

All full-time and part-time benefits eligible employees working in the United States of America who are Actively at Work for the Employer, and who ARE participating in a defined benefit retirement plan. Temporary employees are not eligible.

The waiting period is stated in the *Schedule of Benefits*.

CDI-4AA

#### **Class 2**

All full-time and part-time benefits eligible employees working in the United States of America who are Actively at Work for the Employer, and who are NOT participating in a defined benefit retirement plan. Temporary employees are not eligible.

The waiting period is stated in the *Schedule of Benefits*.

CDI-4AA

### **When does Your insurance become effective?**

If *You* are eligible as of the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* become eligible after the Policy Effective Date, *Your* insurance shall become effective on the 1st or 16th day of the pay period following the date *You* become eligible.

If, because of *Injury* or *Sickness*, *You* are not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the 1st or 16th day of the pay period following the day *You* return to *Active Work*.

CDI-5AA

### **Evidence of Insurability**

If *You* are required to submit Evidence of Insurability, *You* must:

- 1) Complete and sign a health and medical history form provided by *Us*;
- 2) Submit to a medical examination, if requested;
- 3) Submit verification of *Monthly Earnings*;
- 4) Provide any additional information and attending physicians' statements that *We* require; and
- 5) Furnish all such evidence at *Your* own expense.

CDI-47AA

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

*You* pay the entire cost of *Your* coverage.

CDI-6AA

### **Is premium payable while You receive benefits?**

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

CDI-45AA

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

### **Effect on Actively at Work Provision**

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* fail to satisfy the *Actively at Work* requirement as stated in the *Are You eligible for this insurance?* provision. *You* will receive credit for time covered under the Prior Policy. This credit will be applied toward satisfaction of service waiting periods, *Elimination Periods* or any other periods of the same or similar provisions under the Policy.

### **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 benefit which would have been payable under the terms of the Prior Policy if it had remained in force. The benefits payable under the Policy will be reduced by any benefits paid under the Prior Policy for the same *Disability*.

Benefits will end on the earliest of the following:

- 1) the date that benefits would terminate in accordance with the provisions of the Policy; or
- 2) the date that benefits would terminate under the Prior Policy if it had remained in force.

The Prior Policy is the group disability insurance policy issued to the Employer by Continental Casualty Company whose coverage terminated as of the Policy Effective Date.

CDI-7AB

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

*You* will receive credit toward satisfaction of the *Pre-existing Condition* time periods under the Policy for the time *You* were covered under the Prior Policy. If, after applying the time covered under the Prior Policy, *Your Disability* is due to a *Pre-existing Condition*, benefits shall be the lesser of:

- 1) the benefits payable under the Policy; or
- 2) the benefits that would have been payable under the Prior Policy if it had remained in force, taking into account the *Pre-existing Condition* provision, if any, of the Prior Policy.

CDI-8AA

## ***LONG TERM DISABILITY BENEFITS***

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

*Disability* or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.

CDI-9AA

#### **Occupation Qualifier**

*Disability* means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

- 1) continuously unable to perform the *Material and Substantial Duties of Your Regular Occupation*; and
- 2) not working for wages in any occupation in which *You* are or become qualified by education, training or experience.

CDI-10CB

## Earnings Qualifier

You may be considered *Disabled* during and after the *Elimination Period* in any month in which You are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that You are unable to earn more than 80% of *Your Monthly Earnings* in any occupation for which You are qualified by education, training or experience. On each anniversary of *Your Disability*, We will increase the *Monthly Earnings* by the lesser of the current annual percentage increase in *CPI-W*, or 10%.

You are not considered to be *Disabled* if You are able to earn more than 80% of *Your Monthly Earnings*. Salary, wages, partnership or proprietor draw, commissions, bonuses, or similar pay, and any other income You receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

CDI-13AB

## 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* under the Occupation Qualifier or the Earnings Qualifier.

CDI-14AA

## What is the Elimination Period and how is it satisfied?

The *Elimination Period* begins on the day You become *Disabled*. It is a period of continuous *Disability* which must be satisfied before You are eligible to receive benefits from Us. You must be continuously *Disabled* through *Your Elimination Period*.

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 one-half the *Elimination Period* as shown in the *Schedule of Benefits* not to exceed 90 days. The days that You are not *Disabled* will not count toward *Your Elimination Period*.

Any increases You receive in *Monthly Earnings* during *Your* return to work period will not be taken into consideration when calculating *Your LTD Monthly Benefit*.

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

## 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*.

CDI-15AA

## What Disability Benefit are You eligible to receive?

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

- 1) an *LTD Monthly Benefit*, 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.

CDI-16AA

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

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

An *LTD Monthly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

We will calculate *Your Gross LTD Monthly Benefit* amount as follows:

- 1) Multiply *Your Monthly Earnings* by 66 2/3%.
- 2) The maximum *Gross LTD Monthly Benefit* is \$20,000.
- 3) Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit*.
- 4) Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.

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

CDI-17AB

## **How do We define Earnings?**

Base Pay plus bonuses, incentive compensation, variable compensation and overtime. Bonus, incentive compensation, variable compensation and overtime will be the total from the prior calendar (Jan – Dec) year. Base Pay will be as of the date of disability.

CDI-19AA-AGRIBANK

## **What are the Deductible Sources of Income?**

- 1) *Disability* benefits paid, payable, or for which there is a right under:
  - a) The Social Security Act, including any amounts for which *Your dependents* may qualify because of *Your Disability*,
  - b) Any Workers Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
  - c) Occupational accident coverage provided by or through the Employer;
  - d) Any Statutory Disability Benefit Law;
  - e) The Railroad Retirement Act;
  - f) The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
  - g) The Canada Old Age Security Act;
  - h) Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
- 2) *Disability* benefits paid under:
  - a) Any group insurance plan provided by or through the Employer, and
  - b) Any sick leave or salary continuance plan provided by or through the Employer.
- 3) Retirement benefits paid under the Social Security Act including any amounts for which *Your dependents* may qualify because of *Your* retirement;
- 4) Retirement and *Disability* benefits paid under a Retirement Plan provided by the Employer except for amounts attributable to *Your* contributions;

## **Proration of Lump Sum Awards**

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

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

CDI-20AB

## **What other sources of income are not deductible?**

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

- 1) deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- 2) credit *Disability* insurance;
- 3) pension plans for partners;
- 4) military pension and *Disability* income plans;
- 5) franchise *Disability* income plans;
- 6) individual *Disability* income plans;
- 7) a *Retirement Plan* from another Employer;
- 8) profit sharing plans;
- 9) thrift or savings plans;
- 10) individual retirement account (IRA);
- 11) tax sheltered annuity (TSA);
- 12) stock ownership plan.

CDI-21AB

## **Can You work and still receive benefits?**

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

CDI-22AA

### **Work Incentive Benefit**

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

The Work Incentive Benefit will be calculated during the first 12 months of *Gainful Employment* as follows:

- 1) The *Net LTD Monthly Benefit* amount and *Disability Earnings* amount will be added together and compared to *Monthly Earnings*.
- 2) If the total amount in Item 1 exceeds 100% of *Monthly Earnings*, the Work Incentive Benefit amount will be equal to the *Net LTD Monthly Benefit* reduced by the amount of the excess.
- 3) If the total amount in Item 1 does not exceed 100% of *Monthly Earnings*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* amount.

After the first 12 months of *Gainful Employment*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* amount less 50% of *Disability Earnings*.

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

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

CDI-23AB

## **What is the minimum Net LTD Monthly Benefit payable under this program?**

The *Net LTD Monthly Benefit* payable for *Disability* will not be less than \$100 or 10% of *Your Gross LTD Monthly Benefit*, whichever is greater. The minimum *Net LTD Monthly Benefit* does not apply if *You* are *Gainfully Employed*.

CDI-25AB

### **What happens if Your other benefits increase?**

The *Net LTD Monthly Benefit* will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above.  
CDI-26AB

### **How long will You receive benefits under this program?**

We will send You a payment for each month of *Disability* up to the *Maximum Period Payable* as shown in the *Schedule of Benefits*. Payment of benefits is also subject to any benefit duration limitation pertaining to Your *Disability*.  
CDI-27AB

### **What happens if Your Disability recurs?**

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

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

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

*Disability* must recur while Your coverage is in force under the Policy.  
CDI-28AA

## **EXCLUSIONS AND LIMITATIONS**

### **What are the exclusions and limitations under this program?**

The Policy does not cover any loss caused by, contributed to, or resulting from:  
CDIX-1AA

- declared or undeclared war or an act of either;  
CDIX-2AA

- a *Pre-existing Condition*;  
CDIX-4AA

- attempted suicide, while sane or insane, or intentional self-inflicted *Injury* or *Sickness*;  
CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;  
CDIX-6AA

- *Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit.  
CDIX-3AA

## **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 at the end of the period for which premium has been paid if the Employer fails to pay the required premium for *You* within 31 days after the premium due date, except for an inadvertent error; or
- 3) the date *You*:
  - a) are no longer a member of a class eligible for this insurance,
  - b) withdraw from the program,
  - 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 Employer have agreed in writing in advance of the leave to continue insurance during such period. Orders to active military service for 2 months or less will be covered subject to continued payment of premium.

Termination will not affect a covered loss which began before the date of termination.

CDI-30AB

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

In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), *Your* insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the required premium continues to be paid.

*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 Employer 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 Employer.

CDI-31AB

## **SUPPLEMENTAL BENEFITS AND SERVICES**

### **CONVERSION PRIVILEGE**

#### ***What are Your conversion options if You end employment?***

If *You* end employment with the Employer, *Your* coverage under the Policy will end. *You* may be eligible to purchase insurance under the group conversion policy. To be eligible, *You* must have been insured under the Employer's group plan on the date *You* end employment and for at least 12 consecutive months. *We* will consider the amount of time *You* were insured under *Our* plan and the plan it replaced, if any.

*You* must apply for insurance under the conversion policy, and pay the first (annual/semi-annual) premium within 31 days after the date *Your* employment ends.

The conversion policy will be at the premium rate and on the form then being made available by *Us* for conversion.

*You* are not eligible to apply for coverage under the group conversion policy if:

- 1) *You* are or become insured under another group long term disability plan within 31 days after *Your* employment ends;
- 2) *You* are *Disabled* under the terms of the Policy;
- 3) *You* recover from a *Disability* and do not return to work for the Employer;
- 4) *You* are on a leave of absence; or
- 5) *Your* coverage under the Policy ends for any of the following reasons:
  - a) the Policy is canceled;
  - b) the Policy is changed to exclude the class of employees to which *You* belong;
  - c) *You* are no longer in an eligible class;
  - d) *You* end *Your* working career or retire and receive payment from the Employer's *Retirement Plan*; or
  - e) *You* fail to pay the required premium under the Policy.

CDI-32AB

## **SUPPLEMENTAL MONTHLY PENSION ACCRUAL BENEFIT**

### **What is the Supplemental Monthly Pension Accrual Benefit?**

If *You* are *Disabled* and receiving a *Monthly Benefit*, and are not *Gainfully Employed*, a Supplemental Monthly Pension Accrual Benefit is payable to *Your Employer* on *Your* behalf.

To be eligible for the Supplemental Monthly Pension Accrual Benefit, *You* must

- 1) be an eligible member of Class 2 as defined in the Policy; and
- 2) have been a participant in the Employer's Retirement Savings Plan(s) for at least 12 months prior to your *Date of Disability*.

Payment of the Supplemental Monthly Pension Accrual Benefit is calculated as the lesser of the following:

- 1) **5%** of *Your average Monthly Earnings* as calculated over the last 12 months of employment prior to *Your Date of Disability* (or *Your* period of employment with the Employer if less than 12 months);
- 2) The maximum allowable by law;
- 3) The average monthly contribution made by *Your Employer* to *Your* pension plan over the last 12 months (or *Your* period of employment with the Employer if less than 12 months) of employment prior to *Your Date of Disability*.

If *Your* monthly earnings exceed the Social Security Taxable Wage Base in effect on *Your Date of Disability*, *We* will pay your Employer 5% of your *Monthly Earnings* that exceeds the Social Security Taxable Wage Base, not to exceed the maximum amount allowable by law.

### **WITH RESPECT TO ALL FORMER 8TH DISTRICT EMPLOYEES IN CLASS 2 , HIRED PRIOR TO JANUARY 1, 1993:**

If *You* are *Disabled* and receiving a *Monthly Benefit*, Payment of the Supplemental Monthly Pension Accrual Benefit is calculated as the lesser of the following:

- 1) 5% - 13%\* of *Your average Monthly Earnings* as calculated over the last 12 months of employment prior to *Your Date of Disability* (or *Your* period of employment with the Employer if less than 12 months);
- 2) The maximum allowable by law;
- 3) The average monthly contribution made by *Your Employer* to *Your* pension plan over the last 12 months (or *Your* period of employment with the Employer if less than 12 months) of employment prior to *Your Date of Disability*.

\**Your Employer* has provided *Us* with a list of each employee's Supplemental Pension Benefit percentage to be kept on file for the purpose of providing this additional benefit.

If *Your* monthly earnings exceed the Social Security Taxable Wage Base in effect on *Your Date of Disability*, *We* will pay your Employer 6.2% of your *Monthly Earnings* that exceeds the Social Security Taxable Wage Base, not to exceed the maximum amount allowable by law.

### **What is the Supplemental Monthly Pension Accrual Benefit while You are working?**

If You are *Disabled* as defined by the Earnings Qualifier and are *Gainfully Employed*, and your monthly *Disability Earnings* are from 20% through 80% of your indexed pre-disability *Monthly Earnings*, the Pension Accrual Benefit will be based on the percentage of income You are losing due to your *Disability*, according to the following steps:

1. Subtract your *Disability Earnings* from *Your Monthly Earnings*;
2. Divide the answer in step 1 by your *Monthly Earnings*. This is your percentage of lost earnings.
3. Multiply your Pension Accrual Benefit by the percentage of lost earnings calculated in Step 2.

This is the amount payable to Your Employer.

Payment of the Supplemental Monthly Pension Accrual Benefit is made directly to *Your Employer* on *Your* behalf. *Your Employer* may deposit such payments into *Your Employer's* sponsored Money Purchase Pension Plan if *Your Employer* determines that such contributions may be accepted by the plan.

We do not act as plan administrator or trustee of *Your Employer's* sponsored Money Purchase Pension Plan, therefore We cannot make the above determination.

If *Your Employer* or the trustee of *Your* plan determines that the benefits payable under this provision cannot legally be accepted by the pension plan, We will, upon written request from *Your Employer*, make the Supplemental Monthly Pension Accrual Benefit payable to *You*. Such payments may constitute taxable income to *You*.

Supplemental Monthly Pension Accrual Benefit payments will end on the earliest of the following:

- 1) The date *You* are no longer eligible for *Monthly Benefit* payments under the contract;
- 2) The date *You* are no longer eligible to participate in *Your Employer's* defined contribution or defined benefit plan;
- 3) The end of the Maximum Period Payable;
- 4) The date of *Your* death.

CDIO-11AA – AgriBank  
\*\*Benefit subject to State approval.

## **SUPPLEMENTAL MONTHLY 401(K) ACCRUAL BENEFIT**

### **What is the Supplemental Monthly 401(K) Accrual Benefit?**

If *You* are *Disabled* and receiving a *Monthly Benefit*, a Supplemental Monthly 401(K) Accrual Benefit is payable to *Your Employer* on *Your* behalf.

To be eligible for the Supplemental Monthly 401(K) Accrual Benefit, *You* must have been a participant in the Employer's Retirement Savings Plan(s) for at least 12 months prior to *Your Date of Disability* and be an eligible member of:

- 1) Class 2, as defined in the Policy, who is not covered under the Supplemental Monthly Pension Accrual Benefit; or
- 2) any Class, as defined in the Policy, who is hired on or after January 1, 2007.

Payment of the Supplemental Monthly 401(K) Accrual Benefit is calculated as the lesser of the following:

- 1) The maximum allowable by law; or
- 2) The monthly average of the sum of:
  - a) 3% of the total fixed contributions made by *Your Employer* to *Your* 401(k) plan each pay period during the last 12 months (or *Your* period of employment with the Employer if less than 12 months) of employment prior to *Your Date of Disability*; and

b) 0% - 4%, as determined annually by *Your Employer*, of the annual employer profit sharing contribution made by *Your Employer* to *Your* 401(k) plan during the last 12 months (or *Your* period of employment with the Employer if less than 12 months) of employment prior to *Your Date of Disability*.

Payment of the Supplemental Monthly 401(K) Accrual Benefit is made directly to *Your Employer* on *Your* behalf. *Your Employer* may deposit such payments into *Your Employer's* sponsored 401(K) plan if *Your Employer* determines that such contributions may be accepted by the plan.

*We* do not act as plan administrator or trustee of *Your Employer's* sponsored 401(k) plan, therefore *We* cannot make the above determination.

If *Your Employer* or the trustee of *Your* plan determines that the benefits payable under this provision cannot legally be accepted by the 401(k) plan, *We* will, upon written request from *Your Employer*, make the Supplemental Monthly 401(K) Accrual Benefit payable to *You*. Such payments may constitute taxable income to *You*.

Supplemental Monthly 401(K) Accrual Benefit payments will end on the earliest of the following:

- 1) The date *You* are no longer eligible for *Monthly Benefit* payments under the contract;
- 2) The date *You* are no longer eligible to participate in *Your Employer's* 401 (k) plan;
- 3) The end of the Maximum Period Payable; or
- 4) The date of *Your* death.

CDIO-11AB(AGRI)

## ***SURVIVOR INCOME BENEFIT***

### ***What happens if You die while receiving benefits?***

If *You* die after having received a benefit provided by the Policy for at least 12 successive months and during a period for which benefits are payable, *We* will pay a Survivor Income Benefit. This benefit is equal to the amount *You* were last entitled to receive for the month preceding death.

The Survivor Income Benefit shall be payable on a monthly basis immediately after *We* receive written proof of *Your* death. It is payable for 3 months. The benefit shall accrue from *Your* date of death.

This benefit is payable to the beneficiary, if any, named by *You* under the Policy. If no such beneficiary exists, the benefit will be payable in accordance with the *Time and Payment of Claim* provision.

CDI-33AB

## ***COST-OF-LIVING ADJUSTMENT***

### ***What is the Cost-of-Living Adjustment?***

If *You* are receiving benefits, *We* will adjust the *Net LTD Monthly Benefit* or the minimum *LTD Monthly Benefit*, whichever applies, to reflect increases in the cost-of-living. Such adjustment shall begin after *You* have been *Disabled* for one year.

The *Net LTD Monthly Benefit* which is payable after 1 year of *Disability* will be adjusted on a compound annual basis. The percentage increase in the *Net LTD Monthly Benefit* payable will be the lesser of:

- 1) the percentage change in the *CPI-W* for the calendar month that falls 90 days prior to the date the annual adjustment is to be made compared to the same calendar month for the previous year; or
- 2) 3%.

Any increase in the *Net LTD Monthly Benefit* by reason of such Cost of Living Adjustment will not be subject to the maximum *LTD Monthly Benefit* stated in the *Schedule of Benefits*.

Increases in the *Net LTD Monthly Benefit* by reason of such Cost-of-Living Adjustment will be made by *Us* while the *Disability* continues until the applicable *Maximum Period Payable* is reached.

When *Disability* benefits cease for any reason, other than when *Disability* ends and recurs due to the same or related causes within 6 months after the end of a prior *Disability*, the *LTD Monthly Benefit* payable for any future *Disability* will be the amount that would have been payable if this Cost-of-Living Adjustment were not in effect.

Adjustments to be made according to this provision will then be available again for a new period of *Disability* that lasts for one year or more.

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

CDIO-3BB

## **CATASTROPHIC DISABILITY BENEFIT**

### **When will You be eligible to receive a Catastrophic Disability Benefit?**

We will pay a monthly *Catastrophic Disability* Benefit to You if You are receiving *LTD Monthly Benefits* (or *Presumptive Disability Benefits*) and We receive proof that You are *Catastrophically Disabled*. *Catastrophic Disability* Benefits will begin at the end of the *Catastrophic Disability* Elimination Period shown in the *Schedule of Benefits*.

You are *Catastrophically Disabled* when We determine that, due to *Sickness* or *Injury*:

- 1) You are unable to perform, without human assistance or regular supervision from another person, at least 2 of the 6 *Activities of Daily Living*; or
- 2) a deterioration in Your intellectual capacity which requires substantial supervision of You by another person because You engage in behavior which poses a health or safety hazard to You or to others; and
- 3) You are not *Gainfully Employed*.

### **When will Your coverage become effective?**

You will become insured for *Catastrophic Disability* Benefit coverage on Your effective date under the *LTD* plan.

However, the *Catastrophic Disability* Benefit coverage will be delayed if, on Your effective date, You cannot safely and completely perform one or more of the *Activities of Daily Living* without another person's assistance, or verbal cueing, or You have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for Your protection, or for the protection of others. Coverage will begin on the date You can safely and completely perform all of the *Activities of Daily Living* without another person's assistance or verbal cueing, or no longer have a deterioration or loss in intellectual capacity, and do not need another person's assistance or verbal cueing for Your protection, or for the protection of others.

### **How much will We pay if You are Disabled?**

The *Catastrophic Disability* Benefit is 10% of *Monthly Earnings* to a maximum *Catastrophic Disability* Benefit of the lesser of the *LTD* plan maximum *Monthly Benefit* or \$5,000.

This benefit is not subject to Policy provisions which would otherwise increase or reduce the benefit amount such as *Deductible Sources of Income*.

### **When will Your Catastrophic Disability Benefits end?**

*Catastrophic Disability* Benefit payments will end on the earliest of the following dates:

- 1) the date You are no longer *Catastrophically Disabled*;
- 2) the date You become ineligible for *LTD Monthly Benefit* payments; or
- 3) the end of the *Catastrophic Disability Maximum Period Payable* shown in the *Schedule of Benefits*.

### **What claim information is needed for Catastrophic Disability Benefits?**

The Claim Filing Requirements section under the Policy applies to *Catastrophic Disability* Benefit coverage. We may also require an interview with You.

CDIO-5AB

## **CAREGIVER RESPITE BENEFIT**

We will pay *You* a Caregiver Respite Benefit for each day of a Respite Interval, subject to the conditions below:

- 1) *You* must be receiving a Catastrophic Disability Benefit;
- 2) The benefit is payable if Informal Home Care has been provided for at least 6 continuous months for *You* beginning with *Your Date of Disability*;
- 3) The benefit is payable for Companion Care received by *You* in *Your* home or a private residence during a Respite Interval;
- 4) The benefit is equal to the daily Companion Care cost incurred, not to exceed \$100 per day; and
- 5) The benefit is payable to *You* following submission of proof of *Your* incurred costs for Companion Care during the Respite Interval.

**Companion Care** means medically necessary custodial care furnished during a Respite Interval for a minimum of 8 hours per day by a Home Health Care Provider accredited by either the Joint Commission on Accreditation of Health Care Organizations or Community Health Accreditation Program.

**Informal Caregiver** means the person who has primary responsibility of providing Informal Home Care for *You*. A person who is paid for caring for *You* cannot be an Informal Caregiver.

**Informal Home Care** means medically necessary custodial care provided at *Your* home or a private residence by an Informal Caregiver. Such care is provided in lieu of confinement in a nursing home, or care received at *Your* home from a paid provider.

**Respite Interval** means a period of one or more consecutive days during which the Informal Caregiver is temporarily relieved of the Informal Home Care duties. Two Respite Intervals are permitted per calendar year, subject to a cumulative total of 14 days per calendar year. Unused days expire on December 31 and cannot be carried over into any future calendar year.

CDIO-6AA

## **CAREGIVER TRAINING BENEFIT**

We will pay *You* a Caregiver Training Benefit if an Informal Caregiver incurs an expense to be trained to provide Informal Home Care for *You*, subject to the conditions below:

- 1) *You* must be receiving a Catastrophic Disability Benefit;
- 2) Caregiver Training must be provided by a Home Health Care Provider accredited by either the Joint Commission on Accreditation of Health Care Organizations or Community Health Accreditation Program, by a Nursing Home or by a *Hospital* while *You* are receiving the Catastrophic Disability Benefit. If *You* are in a Nursing Home or in a *Hospital*, the Caregiver Training Benefit will only be payable if the training will make it possible for *You* to return to *Your* residence where *You* can be cared for by the Informal Caregiver;
- 3) The amount of the benefit is the cost incurred for the Caregiver Training, subject to \$500 maximum per period of *Disability*;
- 4) The benefit is payable to *You* following submission to *Us* of proof of *Your* costs incurred for Caregiver Training.

**Caregiver Training** means training received by the Informal Caregiver to care for *You* in *Your* residence.

**Informal Caregiver** means the person who has primary responsibility of providing Informal Home Care for *You*. A person who is paid for caring for *You* cannot be an Informal Caregiver.

**Informal Home Care** means medically necessary custodial care provided at *Your* home or a private residence by an Informal Caregiver. Such care is provided in lieu of confinement in a nursing home, or care received at *Your* home from a paid provider.

CDIO-7AA

## **EMERGENCY ALERT SYSTEM BENEFIT**

We will pay You an Emergency Alert System Benefit for the actual cost to rent or lease an emergency alert system which will allow You to remain in Your residence alone, subject to the conditions below:

- 1) You must be receiving a *Catastrophic Disability* Benefit;
- 2) The benefit is payable for a medically necessary emergency alert system, which is a communication system located in Your residence, that is used to summon medical attention in case of a medical emergency;
- 3) Your condition must be such that You could not be left alone were it not for the presence of the emergency alert system;
- 4) The benefit is equal to the lesser of \$25 per month or the actual cost to rent or lease the emergency alert system;
- 5) The benefit is payable to You, in arrears, after every 6 months, following submission of proof of Your incurred costs for the emergency alert system; and
- 6) We will not pay for any charges incurred as a result of installing, servicing, or maintaining the Emergency Alert System. This includes, but is not limited to, charges for normal telephone service while the system is installed or for a home security system.

CDIO-8BA

## **PRESUMPTIVE DISABILITY BENEFIT**

### **What is the Presumptive Disability Benefit?**

When *Injury* results in any of the Specific Losses listed below within 365 days after the date of the *Injury*, You shall be entitled to payment of a Presumptive *Disability* Benefit after the *Elimination Period*. The Presumptive *Disability* Benefit is equal to the *Net LTD Monthly Benefit* and is payable for the length of time stated below or until Your date of death, whichever first occurs. This Benefit is paid in lieu of the *LTD Monthly Benefit*, the Work Incentive Benefit or the Enhanced Work Incentive Benefit.

<b>Specific Loss</b>	<b>Months Payable</b>
Loss of both hands .....	46 months
Loss of both feet .....	46 months
Loss of the entire sight of both eyes .....	46 months
Loss of one hand and one foot .....	46 months
Loss of one hand and the entire sight of one eye .....	46 months
Loss of one foot and the entire sight of one eye.....	46 months
Loss of one hand .....	23 months
Loss of one foot .....	23 months
Loss of the entire sight of one eye.....	15 months
Loss of the thumb and index finger of either hand.....	12 months

After payment of the Presumptive *Disability* Benefit, benefits may continue subject to the other provisions of the Policy. If more than one loss results from any one *Injury*, We will pay only for that loss with the greatest number of months payable.

**Specific Loss** means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof; and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalangeal joints.

CDIO-10AB

## **CLAIM SERVICES**

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

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

#### **Worksite Modification Benefit**

*We* will assist *You* and *Your* Employer 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*, *Your* Employer and *Us*.

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

- 1) \$1,500; or
- 2) 2 months of *Your Net LTD Monthly Benefit*.

#### **Vocational Rehabilitation Service**

Rehabilitation services are available when *We* determine that these services are reasonably required to assist in returning *You* to *Gainful Employment*. Vocational rehabilitation services might include one or more of the following:

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

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

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

#### **Social Security Assistance**

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

CDI-35AB

## **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 Employer 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, P.O. Box 946730, Maitland, FL 32794-6730 or given to *Our* Agent.

#### **Written Proof of Loss**

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

## **Time Limit for Filing Your Claim**

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

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

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

## **Proof of Disability**

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

- 1) The date Your Disability began;
- 2) The cause of Your Disability,
- 3) The prognosis of Your Disability;
- 4) Proof that You are receiving *Appropriate and Regular Care* for Your condition from a Doctor, who is someone other than You or a member of Your immediate family, whose specialty or expertise is the most appropriate for Your disabling condition(s) according to *Generally Accepted Medical Practice*.
- 5) Objective medical findings which support Your Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for Your disabling condition(s).
- 6) The extent of Your Disability, including restrictions and limitations which are preventing You from performing Your Regular Occupation.
- 7) Appropriate documentation of Your Monthly Earnings. If applicable, regular monthly documentation of Your Disability Earnings.
- 8) If You were contributing to the premium cost, Your Employer 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 benefits included 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 as often as We feel reasonably necessary. If so, this will be at Your expense and must be received within 30 days of Our request. Failure to do so 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 deny, suspend or terminate 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 which support 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 Income Benefits 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 Income Benefits. You must tell Us the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AB

### ***Time of Payment of Claim***

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

*We* will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, 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; 4) brothers or sisters; or 5) 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.

CDI-37AB

### ***Can you assign Your benefits?***

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

CDI-38AA

### ***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.

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

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.

CDI-39AA

### ***Subrogation - Right of Reimbursement***

*You* must notify *Us*, in writing, if *You* make a claim against a third party for loss covered by this policy. The statute of limitations applicable to the rights regarding reimbursement or subrogation by *Us* does not begin until *We* receive the notice.

When, after *You* have received full recovery for such loss by reason of any cause of action against a third party, *We* make any additional claim payment in accordance with the provisions of this policy, *We* shall reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Such subrogation and/or right of reimbursement shall be less the pro rata share of *Your* costs, disbursements, reasonable attorney fees and other expenses incurred in obtaining the recovery from the third party.

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 its pursuit of subrogation or recovery.

CDI-41AA22

### ***Fraud***

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.

CDI-42AA

## **UNIFORM PROVISIONS**

### **Entire Contract; Changes**

The Policy, the Employer's application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the Employer 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**

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Employer or *You*, whoever made the statement. No statement of the Employer will be used to void the Policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

### **Legal Actions**

No legal action of any kind may be filed against *Us*:

- 1) within the 60 days after proof of *Disability* 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.

### **Conformity with State Statutes**

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

CDI-40AB

### **General Provisions**

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

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

whichever is later.

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

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

CDI-43AB

## DEFINITIONS

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

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

- 1) working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
- 2) performing the *Material and Substantial Duties of Your Regular Occupation* on a full-time basis.

CDID-1AB

**Activities of Daily Living** means:

- 1) Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- 2) Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
- 3) Transferring – Moving into or out of a bed, chair or wheelchair.
- 4) Bathing – Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- 5) Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- 6) Contenance – Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

CDID-2AA

**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*.

CDID-4AA

**Date of Disability** is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Occupation*.

CDID-5AA

**Disability** or **Disabled** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.

CDID-6AA

**Disability Earnings** is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive. It does not include Social Security, sick pay, salary continuance payments or any other *Disability* payment *You* receive as a result of *Your Disability*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

CDID-7AB

**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.

CDID-8AA

**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*.

CDID-9AA

**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, and which *We* approve and for which *We* reserve the right to modify approval in the future.

CDID-10AB

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

CDID-11AA

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

CDID-20AGross

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

CDID-12AA

**Injury** means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.

CDID-13AA

**Insured Employee** means an employee whose insurance is in force under the terms of the Policy.

CDID-14AA

**LTD** means Long Term Disability.

CDID-35AA

**Male pronoun**, whenever used, includes the female.

CDID-16AA

**Material and Substantial Duties** means the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered.

CDID-17AA

**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.

CDID-18AA

**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*.

CDID-32AA

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

CDID-19AA

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

CDID-20ANet

**Pre-existing Condition** means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing for loss incurred or *Disability* commencing after *You* have been insured under the Policy for a period of 12 consecutive months.

CDID-21BA22

**Regular Occupation** means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* Employer.

CDID-22BA

**Retirement Plan** means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.

CDID-24AA

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

CDID-28AA

**Sickness** means sickness or disease causing *Disability* which begins while *Your* coverage is in force.

CDID-26AA

**We, Our** and **Us** mean the Hartford Life and Accident Insurance Company.

CDID-29AA

**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.

CDID-30AA

## ***IMPORTANT ERISA WELFARE PLAN INFORMATION***

The following section contains information provided to You at the request of the Plan Administrator of Your Plan to meet certain requirements of the Employee Retirement Income Security Act of 1974, as amended, (ERISA). All inquiries related to the following material should be referred directly to Your Plan Administrator.

### ***DISCRETIONARY AUTHORITY***

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto. The plan administrator and other plan fiduciaries have discretionary authority to determine Your eligibility for and entitlement to benefits under the Policy. The plan administrator has delegated sole discretionary authority to Hartford Life and Accident Insurance Company to determine Your eligibility for benefits and to interpret the terms and provisions of the plan and any policy issued in connection with it.

**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN  
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH  
INSURANCE GUARANTY ASSOCIATION LAW**

If the insurer who issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

**Minnesota Life & Health Insurance Guaranty Association  
55 Fifth Street East  
Suite 750  
St. Paul, MN 55101  
(651) 222-2799**

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to \$300,000. Subject to this \$300,000 limit, the Guaranty Association will pay up to \$300,000 in life insurance death benefits, \$100,000 in net cash surrender and net cash withdrawal values for life insurance, \$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal value, \$100,000 in annuity net cash surrender and net cash withdrawal values, \$300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$7,500,000, the \$7,500,000 shall be prorated among all claimants.

These are the maximum claim amounts. Coverage by the guaranty association is also subject to the other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of the amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

The coverage provided by the Guaranty Association is not a substitute for using care in selecting insurance companies that are well managed and financially stable. In selecting an insurance company or policy, you should not rely on coverage by the Guaranty Association.

This notice required by Minnesota state law to advise policyholders of life, annuity or health insurance policies of their rights in the event their insurance carrier becomes financially insolvent. This notice in no way implies that the company has any type of financial problems. All life, annuity and health insurance policies are required to provide this notice.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.