Voluntary Short-Term Disability Insurance

Employee Benefit Booklet

The University of Texas System

Group Number: GFZ71778-0001

Class 1-01

11/2009

FORT DEARBORN LIFE
Insurance Company®

Administrative Office:
2400 Lakeside Boulevard •
Richardson, Texas 75082-7399

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

Having issued Group Policy No. GFZ71778-0001

(herein called the Policy)

to

The University of Texas System
(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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.
00095 TX

Group Voluntary Short-Term Disability Insurance Certificate
Participating

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your Local Benefits Office.

You may call Fort Dearborn Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-348-4512

You may also write to Fort Dearborn Life Insurance Company at:

1020 31st Street, Downers Grove, IL 60515-5591

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para informacion o para someter una queja:

Peude communicarse con su Local Beneficio Oficina.

Usted puede llamar al numero de telefono gratis de Fort Dearborn Life Insurance Company para informacion o para someter una queja al:

1-800-348-4512

Usted tambien escribir a Fort Dearborn Life Insurance Company al:

1020 31st Street, Downers Grove, IL 60515-5591

Puede comunicarse con el Departamento de Seguros de Texas para conseguir informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con al Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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SCHEDULE OF BENEFITS

Policyholder:	The University of Texas System
Policy Number:	GFZ71778-0001
Effective Date:	September 1, 2009
Annual Enrollment Period:	7/1 to 7/31
Eligibility: **Class 01**	All active benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment.
Eligibility Waiting Period:	The date of hire or the first day of the month following the date of hire, whichever *You* elect when *You* enroll.

Short-Term Disability

STD Benefit	60% of *Your Weekly Earnings* to a maximum of $693 per week subject to reduction by deductible sources of income or *Disability Earnings*.
Elimination Period	14 Days - *Injury* 14 Days – *Sickness* Elimination Period is extended to the later of the period shown above or the expiration of *Your* Sick Leave.
Benefits are Payable on	Day 15 of *Injury* Day 15 of *Sickness;*
Maximum Period Payable	22 weeks following the Elimination Period or until benefits become payable under the Long Term Disability plan, whichever occurs first. For *Disability* caused by a *Pre-Existing Condition*: Up to 4 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	0% of Premium

OTHER FEATURES

- Work Incentive Benefit
- Recurrent Disability
- 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 benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment are eligible.

The *Waiting Period* is shown in the *Schedule of Benefits.*
00001 UTS

When does Your Contributory insurance become effective?

Your Contributory coverage will become effective on the latest of the following dates, provided *You* are *Actively at Work* on that date:

1. If there is no *Waiting Period*, the date *You* are eligible for coverage, if *You* enroll for coverage on or before that date;
2. If *You* sign the *Enrollment Form* during the *Waiting Period*, the date *You* are eligible for coverage;
3. If *You* sign the *Enrollment Form* after the end of the *Waiting Period*, but within 31 days after that day, *Your* coverage will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
4. If *You* do not sign the *Enrollment Form* within this 31-day period, *You* will be considered a late entrant and must wait until the next *Annual Enrollment* to apply for coverage, unless *You* qualify because of a *Change in Family Status*.
    a. Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment* period will become effective on the Policy anniversary date.
    b. Coverage because of a *Change in Family Status* will become effective on the date *You* sign the *Enrollment Form*.

You must be *Actively at Work* for coverage under the Policy to become effective.

Contributory means *You* pay all or a portion of the premium for this insurance coverage.

Enrollment Form means the application *You* complete to apply for coverage under the Policy.
00003

Change in Family Status

If *You* experience a qualified *Change in Family Status*, *You* may enroll for *Contributory* coverage, apply for additional coverage, or request changes to *Your* current *Contributory* benefit program(s) without providing *Evidence of Insurability*, provided the benefit change is consistent with the *Change in Family Status*. *You* must submit the appropriate *Enrollment Form* within 31 days of the *Change in Family Status*.
00004

Change in Family Status means changes in the status of *Your* family, including but not limited to:

1. *You* get married;
2. *You* have a dependent child, or *You* adopt or become the legal guardian of a dependent child;
3. *Your Spouse* dies or *You* become divorced;
4. *Your* dependent child becomes emancipated or dies;
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance, or;
6. *You* have a change in classification which results in *You* changing from part-time to full-time, or full-time to part-time.

00005-A

What happens if* You *take a leave of absence?

You have two options if *You* take a leave of absence:

1. *You* may continue *Your* coverage for the period of the leave of absence provided *Your* premium is paid; or
2. *You* may terminate *Your* coverage effective the date *Your* leave of absence begins.

If *You* continue *Your* coverage and return to work on the first work day following the end of *Your* leave of absence, *Your* coverage will continue.

If *You* do not return to work on the first work day following the date *Your* leave of absence ends, *Your* coverage will terminate on the date *Your* leave of absence ended.

If *You* terminate *Your* coverage when *Your* leave of absence begins or before the end of the approved leave of absence period, *You* must re-enroll when *You* return to work after a leave of absence. *Evidence of Insurability* is required if *You* do not re-enroll within 31 days of returning to work after a leave of absence.
00000 UTS

When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late entrant, 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.

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*.
00006

What is an Annual Enrollment period?

Unless otherwise specified, *Annual Enrollment Period* means the period of time prior to the Policy anniversary date. *Your Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Eligible Employees may enroll in the Plan, apply for additional coverage, or request changes to their current Voluntary Benefit program(s) only during the *Annual Enrollment*, unless they qualify because of a *Change in Family Status*. Employees hired after an *Annual Enrollment* period may enroll within 31 days following their eligibility date. If a new Employee does not elect Voluntary coverage within that time period, he must wait for the next the *Annual Enrollment* to enroll unless they qualify because of a *Change in Family Status*.

Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment* period will become effective on the Policy anniversary date.
00007

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*.
00008

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.
00010

What happens if We are replacing an existing policy?

Benefits are payable for a *Disability* caused by, contributed to, or resulting from a *Pre-existing Condition*. The *Gross STD Weekly Benefit* is equal to 60% of *Your Weekly Earnings* up to a maximum *Gross STD Weekly Benefit* of $693 and reduced by the Deductible Sources of Income or *Disability Earnings*. The benefit is payable for up to 4 weeks.
00012 UTS

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 days, we will not:

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

00013

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?

If the institutions are in session, ***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*.

If the institutions are not in session, ***Total Disability*** or ***Totally Disabled*** means that due to *Sickness* or *Injury You* would be continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*, and *Your Disability Earnings*, if any, would be less than 20% of *Your* pre-disability *Weekly Earnings*.
00015 UTS

How do We define Partial Disability?

If the institutions are in session, ***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 80% of *Your* pre-disability *Weekly Earnings*.

If the institutions are not in session, ***Partial Disability*** or ***Partially Disabled*** means that*:*

1. During the *Elimination Period You* would be unable 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* would be able to perform some but not all of the *Material and Substantial Duties of Your Regular Occupation;* and *Your Disability Earnings*, if any, would be at least 20% but less than or equal to 80% 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.
00017 UTS

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*.
00019

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 7 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 60%.
2. The maximum *STD Weekly Benefit* is $693.
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.
00023-A UTS

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?

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 *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 UTS

What are the Deductible Sources of Income?

The *Gross STD Weekly Benefit* under the Policy will be reduced by *Disability* benefits paid under any State Teachers Retirement System, Public Employees Retirement System or School Employees Retirement System.

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 UTS

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?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 14 days 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 14 days after the end of a prior *Disability* is subject to:

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

Disability must recur while *Your* coverage is in force under the Policy.
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. a *Pre-Existing Condition*, except as provided under the "What happens if We are replacing an existing policy?" section;
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. Occupational *Injury* or *Sickness;*
6. 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 UTS

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 90 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. request termination of coverage under the Policy,

   c. are retired or pensioned, or

   d. cease work because of a leave of absence (see Extension of Coverage below), 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. Orders to active military service for 2 months or less will be covered subject to continued payment of premium.

Termination will not affect *Your* claim for a covered loss which began while the coverage was in force.
00034 TX UTS

Extension of Coverage

Subject to payment of the required premium when due, *Your* coverage under the Policy will be extended until the end of the period shown for each of the following reasons:

1. leave of absence, agreed to in writing by *Your* Employer: 24 months

2. sabbatical leave, agreed to in writing by *Your* Employer: 24 months
00000 UTS

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*.
00035 UTS

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Written Proof of Loss

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

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 91 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 91 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

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

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

Proof of *Disability*

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

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;
4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your 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 but not more frequently than once every 3 months. 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 TX

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.

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

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 in defense to claim under the Policy unless it is contained in a written application signed by the Insured and a copy of such application is or has been given to him or to his personal representative.

Legal Actions

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

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

Clerical Error

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

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

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

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

Misstatement of Age

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

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

Incontestability

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

Conformity with State Statutes and Regulations

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

Workers' Compensation or State Disability Insurance

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

00043 TX

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 an 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. are paid regular earnings by the *Policyholder*.

If the institutions are not in session, *Actively at Work* means *You* would be working for the *Policyholder* for earnings that are paid regularly and *You* would be able to perform the *Material and Substantial Duties* of *Your Regular Occupation*.

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 UTS

Accumulated Sick Leave or Salary Continuation means continued payments to *You* by *Your* Employer of all or part of your *Weekly Earnings* after *You* become *Disabled* as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all Employees covered under the Policy. *Accumulated Sick Leave or Salary Continuation* does not include compensation paid to *You* by *Your* Employer for work *You* actually perform after *Your Disability* begins. Such compensation is considered *Disability Earnings*.
00046

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

Annual Enrollment Period means a period of time during which eligible Employees may apply for Voluntary STD coverage or request changes to their STD benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.
00048

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

Contributory means you pay all or a portion of the premium for this insurance coverage.
00051

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 20% 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

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* 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

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

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy.
00078 TX

Pre-existing Condition means a condition which;

1. was caused by, or results from a *Sickness* or *Injury* for which *You* received medical treatment, or advice was rendered, prescribed or recommended whether or not the *Sickness* was diagnosed at all or was misdiagnosed within 3 months prior to *Your* effective date; and
2. results in a *Disability* which begins in the first 12 months after *Your* effective date.

00079

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

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 will equal the greater of:

1. 1/52nd of *Your* last reported gross annual income from *Your Employer* in effect on the day immediately prior to *Your Date of Disability*; or
2. 1/52nd of *Your* gross annual income from *Your Employer* in effect on the September 1 immediately prior to *Your Date of Disability*.

It includes:

1. hazardous duty pay;
2. longevity pay;

3. employee contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee Retirement Plan or deferred compensation arrangement; and

4. amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1. commissions;

2. bonuses;

3. overtime pay;

4. *Your* Employer's contribution on *Your* behalf to a Retirement Plan or deferred compensation arrangement; or

5. any other extra compensation.

00088 UTS (Rev. 1109)

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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